

# bulletin

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The official member magazine of the **American Academy of Otolaryngology—Head and Neck Surgery**

**MARCH 2016**

Explore the **voices**  
of your patients

Comprehensive otolaryngologic care includes inquiring about the voice and your patient's daily communication needs

**17**

2016 code changes **26**

Regent<sup>SM</sup>  
progress report **28**



arches

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\*See Holstein N. Ginkgo special extract EGb 761 in tinnitus therapy: An overview of results of completed clinical trials. *Fortschr Med* 2001 Jan 11; 118(4): 157-64. Also: Von Boetticher A. Ginkgo biloba extract in the treatment of tinnitus: a systematic review. *Neuropsychiatr Dis Treat* 2011; 7:441-447.

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# Halftime report

**M**arch finds me at the halfway point in my presidential year and the three-year cycle that encompasses it. Now is a good time to reflect on that process, and on what has been done, will be done, and the people who are doing it.

I spent a year as president-elect, serving on the Board of Directors and the Executive Committee, learning how our and other organizations work, doing the intricate work of Academy and Foundation committee assignments, and being mentored by then-President **Gayle E. Woodson, MD**. In October, I took over the reigns as president, and this October I will hand them off to **Gregory W. Randolph, MD**. As immediate past-president, I will continue Board and Executive Committee service, chair the Nominating Committee that selects our future leaders, and (hopefully!) provide some useful advice and institutional memory. The past-president is often tasked with projects that have ongoing impact on our Academy and our Members.

Dr. Woodson is chairing the International Task Force, and **James E. Saunders, MD**, is the Foundation's coordinator for International Affairs. Their efforts will be visible at the International Symposium at September's Annual Meeting in San Diego. It will run concurrently with the other academic offerings—Instruction Courses, Miniseminars, Orals (free papers)—and is open to all Annual Meeting attendees. We hope that this will usher in an era of stronger scientific and collaborative dialogues between U.S. and overseas colleagues.

I have established the ENT Advanced Practice Provider (APP) Education Task Force, chaired by **Karen T. Pitman, MD**, and **Peter D. Costantino, MD**. It is made up of Members and ENT physician assistants interested in exploring education opportunities unique to this audience. I am grateful to the Society of Physician Assistants in Otorhinolaryngology/Head and Neck Surgery (SPAO-HNS) for supporting our Foundation in this very important endeavor. I have every confidence that this task force will put together a comprehensive ENT APP curriculum, utilizing many Academy resources. Establishing such an educational outline will really help our Members as they seek to incorporate APPs into their practices, and dovetail into our initiative to offer associate membership to ENT PAs.

The huge Academy project this year is the creation and implementation of our Qualified Clinical Data

Registry (QCDR), Regent<sup>SM</sup>. This is a Herculean task that has been spearheaded by the Foundation's coordinator for Research and Quality, **Lisa E. Ishii, MD, MHS**, and EVP/CEO **James C. Denny III, MD**, with the help of dedicated Academy staff and physician volunteers **Richard M. Rosenfeld, MD, MPH**, **David L. Witsell, MD, MHS**, **Robert R. Lorenz, MD, MBA**, **Jennifer Shin, MD, SM**, **David R. Nielsen, MD**, and **Rodney P. Lusk, MD**. It has moved from an idea to near-shovel-ready in under a year. The vendor (FIGmd, Inc.) for the interface between physician EMRs and Regent has been engaged, the data dictionary has been populated, and QCDR and PQRS Qualified Registry submissions were delivered to CMS in January. It will roll out by this spring at 38 pilot sites representing all types of ENT practices.

The reason to establish our own registry is to take control of our own measures, so that otolaryngologists are assessed using meaningful criteria. Quality improvement triangulates between Clinical Practice Guidelines (CPGs), which define quality, the data registry, which tracks quality, and Performance Measures, which assess quality. The Performance Measures development task force consists of Dr. Rosenfeld (chair), Dr. Ishii, Dr. Denny, **Jane T. Dillon, MD, MBA**, **Julie L. Goldman, MD**, **Richard V. Smith, MD**, Dr. Nielsen, and **Peter M. Vila, MD, MSPH**.

Some clinical issues and questions we address in an ongoing fashion. These are raised from individual Members, committees, or specialty societies, and brought to the Guidelines Task Force, which meets twice yearly and is headed by Chair **David E. Tunnel, MD** (immediate past-chair **Seth R. Schwartz, MD, MPH**). A result of such a discussion is the Intraoperative Facial Nerve Monitoring Task Force, chaired by **Sonya Malekzadeh, MD**. In the queue for 2016-2017 are clinical practice guideline (CPG) updates on cerumen, BPPV, hoarseness, tonsillectomy, polysomnography, and sudden hearing loss. New CPGs are being developed for rhinoplasty and evaluation of the neck mass in adults.

I have just managed to scratch the surface of what is being done at our Academy and Foundation. Halfway through my term, I remain humbled by the dedication of our staff and volunteers—who are busy people and leaders in their field and yet find the time to contribute so much. I look forward to seeing your name highlighted in the future. ■



**Sujana S. Chandrasekhar, MD**  
AAO-HNS/F President

“

I remain humbled by the dedication of our staff and volunteers—who are busy people and leaders in their field and yet find the time to contribute so much.

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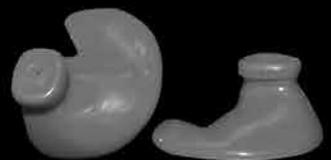


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# Collaboration among specialties

**A**s we prepare for World Voice Day, April 16, I am reminded how important it is to speak with an informed and thoughtful voice. As otolaryngologists we have recognized on many occasions the value of working together within our specialty and speaking with one voice when possible to maximize our influence to effect a desired goal. With each passing month on the job, I become more aware of generalized medical and societal issues that broadly affect physicians and their organizations across the spectrum of medicine. In the face of limited resources, it is critical to either maintain or have access to expertise in areas that may not be your strength. Often that expertise lies outside of the staff and volunteer Members who serve us so well.

Perhaps the most pleasant and unexpected revelation I have experienced as your EVP/CEO is the across-the-board congeniality and collegial sharing of information and experience that is commonplace in the medical association world both at the individual and organizational level. Matters that are not specialty-specific, that occur irregularly and unpredictably, and yet are critical to an organization can be the hardest to maintain expertise in. However, across the house of medicine it is likely that similar occurrences have been dealt with by others and the willingness to impart lessons learned and recommendations in these circumstances is invaluable.

Relationships developed through participation in organizations such as the Council of Medical Specialty Societies (CMSS) and Specialty Societies CEO Coalition (S2C2) allow discussion of these issues and the opportunity to compare solutions to problems and craft appropriate solutions with confidence. Probably the most valuable input over the past year has been from several specialty societies, including ophthalmology, dermatology, neurology, urology, and cardiology, regarding the decision to proceed and form our own Clinical Data Registry. Advice on consultants, vendors, and implementation at every stage of the project has been helpful and allowed us to greatly accelerate our timeline and decrease expenses related to this project. Discussions and input from these groups have allowed us to adopt variations of successful plans that most closely fit our needs.

While the relationships are pleasant, the topics themselves cover a broad spectrum of endeavor.

Our Ethics Committee, chaired by **Susan D. McCammon, MD**, is studying our policy on “expert witness” testimony. The research has included experi-

ences of a number of surgical specialties, particularly neurosurgery and orthopedic surgery. The committee will present recommendations to the Board of Directors for consideration of a comprehensive policy. The experiences, both good and bad, relayed by these societies as well as a survey done through S2C2 will greatly enhance predictability and effectiveness of such recommendations.

The task force to review our international activities, chaired by **Gayle E. Woodson, MD**, has presented initial recommendations to the Board of Directors in the form of a comprehensive business plan addressing international meetings, education, membership, and humanitarian activities. This project was considerably aided by the American Urological Association’s comprehensive plan to promote international relations, which they shared with us, as well as discussions with other specialty societies. We are also looking forward to collaborating with the American College of Surgeons and their “Operation Giving Back.” This program has the potential to allow collaboration, sharing of resources, and expertise across surgical specialties, which will likely increase the benefit to the recipients across the spectrum of humanitarian efforts.

## Workplace violence

Unfortunately, in today’s society another issue, random violence, has become much too common. Workplace violence, involving both internal and external threats, has also been on the upswing. It has become necessary to construct policies to prepare workplaces of all types, including medical practices, for the potential of such tragedy. The following two links were produced by the federal government to help prepare the population: “Active Shooter Situation” training video, from the U.S. Department of Homeland Security [www.youtube.com/watch?v=ol5EoWBRYmo](http://www.youtube.com/watch?v=ol5EoWBRYmo); and “Run! Hide! Fight!: DHS Offers Tips to Survive A Shooting,” [www.youtube.com/watch?v=p4IJA5Zpzz4](http://www.youtube.com/watch?v=p4IJA5Zpzz4). If your workplace does not have a plan, you should consider creating one.

The American Urological Association has recently provided their preparedness plan to our society as well as others, and we are grateful. The plan can be found at the following link: <http://bit.ly/1PiMWyU>.

This and those above are but a few examples of the constructive collaboration that exists broadly among medical associations. ■



**James C. Denneny III, MD**  
AAO-HNS/F EVP/CEO

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In the face of limited resources, it is critical to either maintain or have access to expertise in areas that may not be your strength.  
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AMA HOUSE OF DELEGATES REPORT

# Issues affecting otolaryngology

■ **Liana Puscas, MD, MHS, Chair**, AAO-HNS

Delegation to the AMA House of Delegates

The American Medical Association (AMA) House of Delegates (HOD) held its November 2015 Interim Meeting in Atlanta, GA. Representing the Academy were **Liana Puscas, MD, MHS**, delegation chair; delegates **Michael S. Goldrich, MD**, and **Shannon P. Pryor, MD**; alternate delegates **Robert Puchalski, MD**, and Academy EVP/CEO, **James C. Denny III, MD**.

In response to two prior resolutions asking for the AMA to evaluate the issue of hearing aid coverage by Medicare and other health plans, the AMA's Council on Medical Service prepared a report addressing this topic. After discussion of the report's recommendations at the HOD and its reference committees, and with amendments supported by the AAO-HNS, existing AMA policy was amended to read:

1. That the AMA continue to support early hearing detection and intervention to ensure that all infants receive proper hearing screening, diagnostic evaluation, intervention and follow-up in a timely manner.
2. That the AMA advocate that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. That the AMA support public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams, hearing services, and devices, including digital hearing aids.
4. That the AMA support hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability, and normal wear and tear.
5. That the AMA encourage private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of



hearing aid purchases, hearing-related exams, and related services.

6. That the AMA support coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit.

The AMA also voted to support a ban on direct-to-consumer advertising (DTCA) for prescription drugs and implantable medical devices. Only the U.S. and New Zealand allow DTCA. While this practice does raise awareness of certain diseases and therapies, which may improve the health of patients, overall the HOD decided a ban against the practice was in the best interest of patients. Since the ultimate goal of DTCA is to drive utilization of a specific product, the potential educational benefits of DTCA were outweighed by the increased cost of new drugs when similarly effective cheaper options are available, and by the cost in time that occurs when physicians must specifically address the patients' demands for these new drugs rather than spending the time dealing with more pressing health issues of their patients.

The next meeting of the AMA HOD is scheduled for June 11-15, 2016, in Chicago, IL. With questions regarding this report and other AMA HOD activities, please contact [govaffairs@entnet.org](mailto:govaffairs@entnet.org). ■

## Call for Jerome C. Goldstein, MD, Public Service Award nominees

The Jerome C. Goldstein, MD Public Service Award is given annually to recognize an outstanding Member for his or her commitment and achievement in service within the United States, either to the public or to other organizations, when such service promises to improve patient welfare. Any Academy Member in good standing is eligible to be nominated, or to nominate another Member, for this prestigious award. The finalist will be selected on April 12 by the AAO-HNS/F Executive Committee of the Board of Directors. The recipient will be recognized during the 2016 Annual Meeting & OTO EXPO<sup>SM</sup> in San Diego. Deadline for submission of the nominee form is March 31. Please visit our website, [www.entnet.org/content/jerome-c-goldstein-md-public-service-award](http://www.entnet.org/content/jerome-c-goldstein-md-public-service-award) for more information. ■

## BOARD OF GOVERNORS

## Human voice transmits emotion, clarity

■ Ken Yanagisawa, MD,

BOG Secretary

According to the U.S. Census, there are 7.3

billion people in the world, and 322 million in the United States.<sup>1</sup> More than 7 billion human voices speak and exchange ideas with one another each day.

It is not only the exact selection of words, but the intonations, inflections, and associated expressions that create and shape the delivered message. Fine. Fine? FINE! Each variation creates a different impact based simply on the way the word is articulated.

Every April 16 we celebrate World Voice Day (WVD), an opportunity to help people around the globe understand the role and importance of optimal vocal hygiene, to encourage healthy voice habits, and to educate the public about our unique position as otolaryngologist-head and neck surgeons who diagnose and treat individuals with vocal disturbances. For 14 years, the Academy has supported WVD across the country with celebratory meetings and educational lectures, social media awareness spots, and voice screenings.

In our fast-paced world of electronic and digital communication, which relies on keyboard-manufactured words, some have raised concerns about old fashioned, eye-to-eye, direct communication. As an “old-school” advocate, I often prefer and certainly value the emotion, emphasis, and clarity that the human voice so capably transmits.

Who talks and how the words are spoken



define the moment—the sweet and scintillating sound of my wife’s voice as we cherish our many life gifts, the excitement and elation as a son or daughter receives a school acceptance, the sadness and understanding of the hoarse smoker who realizes the gravity of the condition. The delivery of any sensitive or serious patient information deserves live, in-person communication, not computerized portals or impersonal internet interactions. It is critical to ensure patient comprehension, and the opportunity for the provider to offer necessary guidance and support. Our physician voice has immeasurable strength to heal and to provide realistic outlook and hope.

Dissemination of timely and accurate information is key to our goal of patient education. The website and digital information media are invaluable for this application. We are extremely

fortunate that our Academy has assembled an informative webpage describing our numerous and growing campaigns including Kids ENT Health Month (February), World Voice Day (April 16) and Oral Head and Neck Cancer Awareness Week (April 10-16), and Better Hearing and Speech Month (May). More information is available at [www.entnet.org/content/our-campaigns](http://www.entnet.org/content/our-campaigns), under the “About Us” tab.

More than ever, communication among physicians is critical as we all face daily battles to maintain the nobility and independence of our profession, to counter financial constraints, and to foster legislative relationships and strategies. The upcoming AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting March 18-21, in Alexandria, VA, offers an outstanding free opportunity to explore and discuss practice tips, tricks, and successes with colleagues and Academy leadership. Topics to be covered include contemporary practice marketing and management advances, mentoring, ICD-10, and Registry (Regent<sup>SM</sup>) updates. Register at [www.entnet.org/leadershipforum](http://www.entnet.org/leadershipforum). Please consider joining us to learn, and to let your voice and your concerns be heard. ■

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The delivery of any sensitive or serious patient information deserves live, in-person communication, not computerized portals or impersonal internet interactions.

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**Reference**

1. U.S. and World Population Clock. Population Clock. [www.census.gov/popclock/](http://www.census.gov/popclock/). Dec. 31, 2015.

## ■ at the forefront

# Hope and hearing for Honduran

■ **Jayne Stevens, MD**, AAO-HNSF Humanitarian Resident Grantee, San Antonio Military Medical Center, San Antonio, TX

Arriving at the airport in Tegucigalpa, Honduras, our group—60 Americans in yellow shirts with “More than Medicine” written on them—was certainly easy to locate. With people arriving from Texas, Tennessee, North and South Carolina, and several other states, the excitement level was high for the upcoming eight-day mission to Guaimaca.

The mission took place at the Baptist Medical and Dental Mission International facilities in Guaimaca, Honduras, and in several nearby surrounding villages. Guaimaca, which is located northeast of the nation’s capital, is a rural town with a primarily agricultural economy. The hospital provides the only medical care to the surrounding areas, with a Honduran physician on call at all times. The facility also serves to host humanitarian medical and surgical missions, our group being one of these.

Our team, which traveled as part of TIME for Christ Global Ministries, consisted of surgical teams for otolaryngology, general surgery, orthopedic surgery, and obstetrics/gynecology as well as primary care teams for daily missions to local villages. After a grueling 13-hour clinic the first day, the operating rooms were filled, and all of the patients were screened.

Over the next five days, 96 operations were performed, with otolaryngologists per-



forming just under 30 of these. In the local villages, approximately 1,200 patients were evaluated and treated medically, including the many patients with hearing loss who were fitted with solar-powered hearing aids. The days were long, but the gratitude of the

Honduran people was strong motivation for our efforts. Throughout the week, our group, which originally seemed like a uniform sea of yellow shirts to an outsider, became much more heterogeneous as I came to know more about my fellow volunteers. Hearing the

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The days were long, but the gratitude of the Honduran people was strong motivation for our efforts. ... I hope our efforts in Honduras prove to have a lasting and positive impact on the people we encountered.

**Jayne Stevens, MD**  
AAO-HNSF Humanitarian Resident Grantee

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# villages



stories that led each to set aside finances and time to serve in a developing country was truly moving.

I hope our efforts in Honduras prove to have a lasting and positive impact on the people we encountered. Regardless of whether this occurs, I know that the experience has profoundly influenced my perspectives on many topics including humanitarian efforts, healthcare equity, and the efficient use of medical resources. I am thankful to the AAO-HNSF Humanitarian Efforts Committee for its assistance in making this trip possible. I am also thankful to the three otolaryngologists I accompanied: **David S. Parsons, MD, Scott A. Estrem, MD, and John R. Blumer, MD.** Their excellent guidance and teaching was valuable, and their demonstration of selflessness in service to others was inspiring. ■



## PROJECT 535: a unique advocacy opportunity

The AAO-HNS, in collaboration with the Board of Governors, is recruiting Academy Members as “key contacts” for each Congressional district—435 in the U.S. House of Representatives and 100 in the U.S. Senate. PROJECT 535 will help establish a “grasstops” database of voting physicians who are willing to act when the specialty must collectively advocate on national issues, including scope of practice, truth in advertising, medical liability reform, GME funding, and Medicare reimbursement.

Interested, but unsure of the time commitment? PROJECT 535 advocates will be contacted by Academy staff when an issue of concern is being

considered on Capitol Hill. The message will contain instructions, email addresses, and a pre-written message for PROJECT 535 participants to use when contacting their assigned Member(s) of Congress.

While we are more than 30 percent to PROJECT 535’s goal of full Congressional coverage, with the 2016 legislative session underway, volunteers may still be needed in your state and/or Congressional District.

To sign up, contact the AAO-HNS Legislative Advocacy team at [govtaffairs@entnet.org](mailto:govtaffairs@entnet.org). If you are unsure of your Congressional District, we can help. Although our specialty is small in numbers, a few

minutes of your time can ensure every Member of Congress hears our voice! ■



# New task forces focus on education

■ **Sonya Malekzadeh, MD,**

AAO-HNSF former Coordinator for Education

The AAO-HNSF has assembled four education task forces to address important issues concerning our Members and the profession. I am honored to be involved in many of these efforts and to serve as chair for two of these groups.

The **Simulation Task Force** was formed in 2011 to define the current state of simulation, to investigate its role and future potential in otolaryngology-head and neck surgery, and to provide educational resources for AAO-HNS Members.

Under the leadership of **Ellen S. Deutsch, MD**, the Simulation Task Force has accomplished:

- Initiation of Simulation Open Forums, at both the Combined Otolaryngology Spring

Meetings (COSM) and the AAO-HNSF Annual Meeting & OTO EXPO<sup>SM</sup>, has brought together like-minded individuals to discuss interests, challenges, and opportunities in simulation. An active ENTConnect community engages simulation Members in ongoing collaboration and exploration.

- Launch of the SimTube Project, a national initiative for simulation-based educational research with the immediate goal of assessing the usefulness of a low-cost, low-tech simulator in learning myringotomy and tube placement, and the larger goal of establishing an infrastructure that could support multiprogram collaboration for more complex simulation-based educational research in the future. More than 60 U.S. residency

programs now participate in the study.

- Numerous Annual Meeting Miniseminars highlighting current education efforts and advanced technology in simulation while also demonstrating the value of simulation in quality of care and systems improvement.

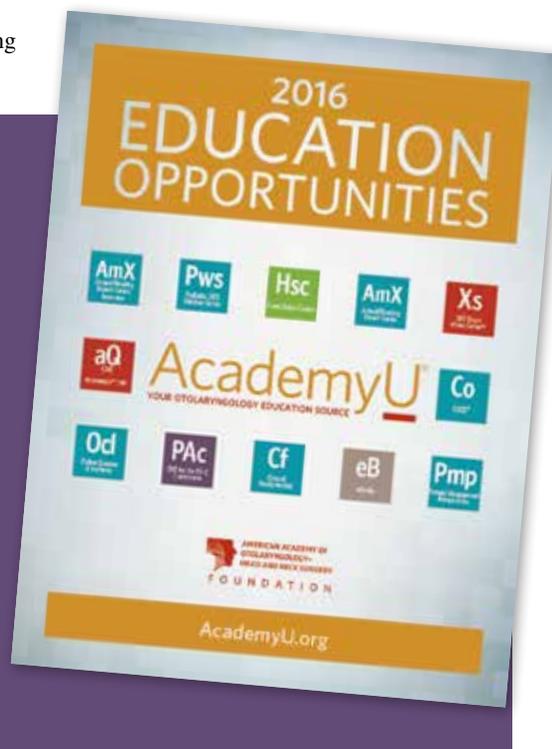
Recognizing the expanding role of simulation in education, research, and quality, the task force has recently submitted an application to become a Foundation committee. This new designation will permit a formal and permanent structure for furthering Member opportunities and engagement. Dr. Deutsch and **Gregory J. Wiet, MD**, will chair the committee.

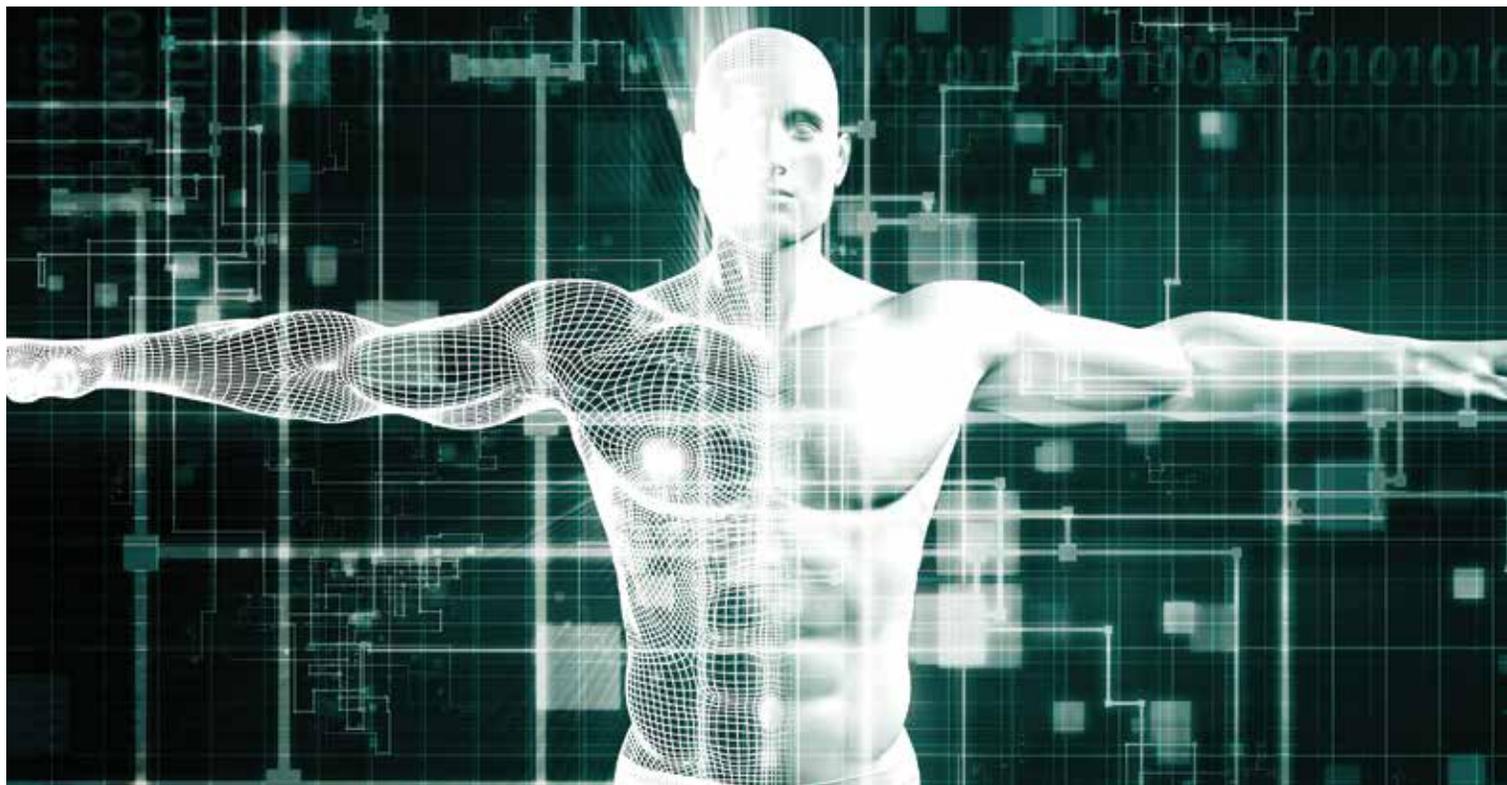
The **Comprehensive Curriculum Task Force** stemmed from the 2013 Board of Directors Strategic Planning meeting where Academy leadership acknowledged the need for a core curriculum in otolaryngology. The Otolaryngology Comprehensive Curriculum will serve as a lifelong, continually expanding learning and assessment tool for otolaryngology professionals. The content and structure will meet the needs of students, residents, allied health colleagues, and all practicing physicians engaged in MOC and lifelong learning. The online format will cover the otolaryngology scope of knowledge, provided in various educational formats, to guide and address cognitive and technical skills. The “living” content will be kept current with frequent updates so users can be assured they are participating in a rich and growing educational program.

The task force believes this to be an ideal opportunity to unite the specialties around education, reduce duplicative efforts across societies, and to provide a comprehensive education platform for our specialty. A working group comprised of society representatives

## AcademyU<sup>®</sup> Education Opportunities

The new AcademyU<sup>®</sup> Education Opportunities can be found with this issue of the *Bulletin*. Inside it you can view all of the education the Foundation has to offer, including a listing of every activity currently available in the new AcademyU<sup>®</sup>. Education Member-volunteers are hard at work on a number of activities that will launch in 2016. Be sure to check [www.academyu.org](http://www.academyu.org) for new education content throughout the year. ■





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The Simulation Task Force investigates the role of simulation and its future potential in otolaryngology-head and neck surgery.

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is finalizing a list of topics and performing an inventory of all existing education content across the specialties. This information will inform the development of future education programming.

The **Intraoperative Nerve Monitoring Task Force**, in existence since fall 2015, will address key issues relevant to facial nerve monitoring during otologic and neuro-otologic surgery. With representation from the American Neurotology Society (ANS) and the American Otological Society (AOS), the task force will focus on:

- Determining current practice in training and performance of nerve monitoring among Academy Members and Residency Program Directors.

- Developing education activities that will provide uniform and standardized training for otolaryngologists to safely and successfully perform the procedure.

- Clarifying the AAO-HNS/F perspective on intraoperative nerve monitoring within the specialty.

AAO-HNS President **Sujana S. Chandrasekhar, MD**, proposed the latest group, **Advanced Practice Professionals (APP) Education Task Force**. With the growing presence of mid-level providers in otolaryngology practices, it is imperative that we provide our colleagues with proper education and training in our field. These efforts will improve their contributions to our practices and patients while also educating AAO-HNS Members on the

benefits of including APPs in the profession. In collaboration with the APP societies, including SPAO-HNS, the task force will design educational programming and provide resources that will allow advanced practice providers and otolaryngologist-head and neck surgeons to work synergistically to improve patient care.

“I have every confidence that this task force will put together a comprehensive ENT APP curriculum, utilizing many Academy resources. Establishing such an educational outline will really help our Members as they seek to incorporate APPs into their practices,” said Dr. Chandrasekhar. **Karen T. Pitman, MD**, and **Peter D. Costantino, MD**, will serve as chairs of this new task force.

Academy task force Members are working hard on topics critical to the Academy and the profession.

“These education task forces really complement the work of the education committees by addressing new and innovative education opportunities for our Members,” said **Richard V. Smith, MD**, coordinator for Education. If you are interested in more information or contributing to any of these projects please email [academyu@entnet.org](mailto:academyu@entnet.org). ■

# The value of membership

Value. Lately everyone is insisting on it, from value-based healthcare to value-added mobile data family plans. With so many options available to us, we're right to insist on value, including in our professional association memberships.

The American Academy of Otolaryngology—Head and Neck Surgery provides value for our Members through professional and public education, research, and health policy and legislative advocacy. As a membership organization, the Academy exists solely for the benefit of our Members and advancement of the specialty—that is, we exist *for you*.

Last month's print issue of the *Bulletin* included a brochure featuring the 2016 membership theme, "Value 4U: You care for patients. We care for YOU." We all feel the uncertainty in today's healthcare environment, and there is enormous value in being part of a unified association that speaks with a clear, loud voice on behalf of individual Members. With strong leadership, a solid strategic plan, and organized action, AAO-HNS is working for your success.

As Executive Vice President and CEO **James C. Denny III, MD**, wrote in his December/January column, "There are a lot of unknowns across the spectrum of physician activities including quality measurement, reimbursement, continuing education and certification, and the overall configuration of the healthcare delivery system. The Academy has been very proactive in preparing for these potential changes and providing our Members the means to offer the best

Value **4U**  
You care for patients. We care for YOU.

patient care in the future." From the development of Regent<sup>SM</sup>, our clinical data registry, to pursuing opportunities for our Members to participate in Alternative Payment Models, the Academy and Foundation are working on your behalf so you can focus on what you do best—providing the best patient care.

The value of membership extends far beyond efforts to provide clarity in these uncertain times. As a Member, you have access to exclusive programs and resources designed just *for you*. Whether you practice general or subspecialty otolaryngology, and regardless of your practice setting, there are Academy resources just *for you*. Most Member benefits fall into one of four categories.



Take an active role in leadership and philanthropic activities that benefit the specialty. Collaborate with other Members who share

your commitment to making significant contributions that advance our mission. From participating in a one-time activity to serving in an elected position, there are many opportunities to make a difference.

- Did you know? More than 1,000 Members are involved in Academy and Foundation committees, sections, and other select groups.
- Did you know? The vast majority of committee meetings at the Annual Meeting are open to all Academy Members. Stop in and see what's going on!



The AAO-HNS Foundation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing education for physicians.

Increase your knowledge of current research and advances in medical practice, and gain

greater competence in performing diagnostic and treatment measures to provide quality care.

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- template appeal letters, and
- advocacy statements.

**INFORMATION EXCHANGE**

Staying up-to-date is crucial in today's ever-changing healthcare landscape. Our publications and communication resources keep you in-the-know about the latest developments and offer opportunities to discuss important topics with your colleagues.

■ Did you know? Our online Member portal, ENTConnect, provides opportunities to connect and collaborate with your peers and

engage in thought-provoking and private conversations.

■ Did you know? You can access the entire *Bulletin* and *Otolaryngology–Head and Neck Surgery* journal, and listen to podcasts of selected journal articles, on your tablet or smartphone.

**4U**

As you browse online at [entnet.org](http://entnet.org) and view our publications throughout the year, you'll notice the Value 4U icon indicating exclusive Member benefits that provide exceptional value. Let these serve as a reminder of the great choice you made when you joined the world's largest organization representing specialists who treat the ear, nose, throat, and related structures of the head and neck. ■

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FROM THE OREBM COMMITTEE

# Publications that may change your practice

■ **Vikas Mehta, MD, MPH**, with input from OREBM Committee Members **Neil D. Gross, MD**, **Samir S. Khariwala, MD**, **Walter T. Lee, MD**, **MHS**, and **Jennifer J. Shin, MD, SM**

In this *Bulletin* article, the Outcomes Research Evidence-Based Medicine (OREBM) Committee shares highlights from a recent key publication in otolaryngology-head and neck surgery. We offer concise summaries of significant findings that may alter current surgical practice.

**D’Cruz AK, Vaish R, Kapre N, et al. Elective versus therapeutic neck dissection in node-negative oral cancer. *N Engl J Med.* 2015 Aug 6;373(6):521-9.**

This prospective, randomized-controlled trial compared elective neck dissection (END) to therapeutic neck dissection (TND) in patients with early-stage (T1-2), node-negative oral cavity squamous cell carcinoma (OSCC). Data from prior studies had been conflicting and thus a well-done, adequately powered

RCT was warranted. END has shown therapeutic benefit in prior studies and provides pathologic staging, but 70 percent of ENDs are node-negative, prompting proponents of TND to raise concerns that END constitutes “over-treatment.”

Eligible patients were between the ages of 18 and 75 years with stage T1 or T2, lateralized OSCC. Patients’ primary tumor and lymph nodes were assessed using physical examination and ultrasonography (US) of the neck. After randomization, patients underwent excision of the primary tumor with adequate margins ( $\geq 5$  mm). Patients in the END group underwent an ipsilateral selective neck dissection (levels I-III). In patients with metastatic nodal disease discovered during surgery (operative findings or frozen section), a modified neck dissection was performed with inclusion of levels IV and V. Patients in the TND group underwent the same primary tumor resection and were then monitored, with modified neck dissection (levels I to V)

only at the time of nodal relapse. All patients who had positive nodes, a primary-tumor depth of invasion of 10 mm or more, or a positive resection margin received adjuvant radiation.

The findings were reported on the first 500 patients (245 in the END group and 255 in the TND group) who had completed at least nine months of follow-up. There were 50 deaths (20.6 percent) in the END group and 79 (31.2 percent) in the TND group. At three years, the corresponding overall survival rates were 80.0 percent and 67.5 percent, respectively (adjusted hazard ratio, 0.63; 95 percent CI, 0.44 to 0.90). There were 81 recurrences (33.3 percent) in the END group and 146 (57.7 percent) in the TND group. At three years, the corresponding rates of disease-free survival were 69.5 percent and 45.9 percent, respectively (adjusted hazard ratio, 0.44; 95 percent CI, 0.33 to 0.57). Of the 114 patients with cervical-lymph-node relapse in the therapeutic-surgery group, 60 (52.6 percent) died



“

These data help settle this decades-old debate regarding OSCC, and indicate that the neck should be addressed primarily even in early-stage lesions to maximize survival.

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of disease progression. The majority of first events (114 events in 146 patients [78.1 percent]) were nodal relapses in the therapeutic-surgery group. Patients with nodal relapse presented with a more advanced nodal stage ( $p=0.005$ ) and a higher incidence of extracapsular spread ( $p<0.001$ ).

**The major finding from this study is that END at the time of the primary tumor resection is associated with a significant overall and disease-free survival advantage (37 percent and 66 percent, respectively).**

Eight patients would need to be treated with END to prevent one death, and four patients would need to be treated to prevent one relapse. The strengths of this study include a prospective, randomized design and a large number of patients. Limitations include the use of ultrasound to detect nodal metastases, which is not as sensitive as other imaging, and the lack of data on treatment morbidity associated with neck dissection. The primary outcome did not focus on the impact of either T1/T2 status or depth of invasion,

which were addressed in only subgroup and post-hoc analyses; understanding the impact of these key factors requires ongoing input from head and neck oncological experts and additional study. Although the authors demonstrate a survival advantage in the elective surgery group, the high rate of pathologically negative dissections in this group (70 percent) should not be ignored. Another issue is that the END group received more adjuvant radiation, which may explain the survival benefit. However, the important point is that END properly identified “high-risk” patients requiring more aggressive therapy. In this context, proven techniques such as sentinel-lymph-node biopsy or potential metastatic biomarkers could help identify subgroups requiring neck dissection and reduce patient morbidity while preserving the rate of disease control. Overall, these data help settle this decades-old debate regarding OSCC, and indicate that the neck should be addressed primarily even in early-stage lesions to maximize survival. ■

# Vocal tips to 'explore'

by **Amanda Hu, MD**, for the AAO-HNS Voice Committee

Voice problems are usually associated with hoarseness, which is characterized by altered vocal quality, pitch, loudness, or vocal effort that impairs communication or reduces voice-related quality of life.

Vocal conditions arise from a variety of sources including vocal overuse or misuse, cancer, infection, or injury. Here are some tips to keep your voice healthy as you “explore your voice” through life.

■ **As you jog along the journey of life, try to maintain a healthy lifestyle.**

This includes exercise, eating healthy, and getting adequate sleep.

■ **When you pass by a clean water source, stop to take a drink.** It is important to keep yourself well hydrated. Your body needs about six to eight glasses of water daily to maintain a healthy voice. This water consumption optimizes the throat’s mucous production and aids vocal fold lubrication.

■ **If you pass by a bistro or concession stand, don’t drink an excessive amount of coffee, tea, soda, or alcohol.** These drinks all dehydrate the body and dry out your vocal folds. These drinks will also worsen acid reflux.

■ **When you approach a fork in the road (or at any time), decide not to smoke!** If you are already a smoker, then decide to quit. Smoking can lead to lung or throat cancer. Primary and second hand smoke can cause significant irritation and swelling of the vocal cords. This will permanently change your voice quality.

■ **Before you start on your journey, remember to warm up your voice.** You should warm up your singing voice and speaking voice before heavy voice use. Warm-ups can be simple, such as gently gliding from low to high tones on different vowel sounds, doing lip trills (like the motorboat sound that kids make), or tongue trills.

■ **If your path gets rocky or you encounter significant background noise, don’t try to talk over it.** Do not abuse or misuse your voice. Avoid habitual yelling, screaming, or cheering. Try not to talk in loud locations. If you routinely need to speak in a loud environment or give a long speech, consider a vocal amplification system such as a microphone.

■ **Take a deep breath of fresh clean air and use good breath support when speaking.** The lungs are the power behind the voice. Don’t wait until you are almost out of air before taking another breath to power your voice.

■ **Obey the signs on the road and listen to the signs from your body.** If your voice is complaining to you, listen to it. Modify and decrease your voice use if you become hoarse in order to allow your voice to recover. Pushing your voice when it is already hoarse can lead to significant problems.

If your voice is hoarse frequently, or for an extended period of time, you should be evaluated by an otolaryngologist (ear, nose, and throat physician). There are many medical conditions that can cause hoarseness, such as infections, reflux, overuse, and cancer. ■





Explore the ●  
**VOICES**  
of your patients

Comprehensive otolaryngologic care includes inquiring about the voice and your patient's daily communication needs



by **Jeanne L. Hatcher, MD**, Atlanta, GA, for the AAO-HNS Voice Committee

**A**s physicians, we are called to care for our patients. As otolaryngologists, that care encompasses many complaints: sinus disease, hearing loss, and head and neck cancer, amongst others. On this April 16, World Voice Day, I encourage you to embrace the WVD theme and "explore" the voice of your patients.

I have had the good fortune of building a practice treating the full spectrum of laryngological patients: those with voice, airway, and swallowing complaints. Some of

my patients—for example, those with chronic cough or paradoxical vocal fold motion disorder—would enter the Voice Center and occasionally wonder if they were in the right place. "My voice is fine," we would hear. It became clear to us that not everyone understands all that a larynx can do.

Often, a laryngeal disorder does not manifest as a voice problem; on some occasions, voice is a minor piece of the puzzle. Over the course of these visits, through education with our multidisciplinary team, these patients understand that they are in the right place.



“

Our trained ears can pick up on roughness, or maybe subtle pitch breaks. In those moments, we have the opportunity to say “Tell me again what kind of work you do.”

They have a sort of “aha moment.” These patients emphasize to us that exploring the voice often means exploring other functions of the larynx as well.

In those with isolated dysphonia complaints, I initially had the naiveté to consider those who were professional voice users to consist of singers only and aspiring performing artists. Over time, I began seeing more professional voice users with a different set of problems: teachers with nodules, ministers with vocal fold atrophy, and call center agents with spasmodic dysphonia and severe muscle tension. I realized how many professional voice users are among us, and how few can actually sing. I had an “aha moment” of my own. So, now I realize many of our patients are professional voice users. Despite the glamor of a professional voice user being a well-known performing artist, it is difficult to ignore all the professions requiring daily voice use.

A recent patient of mine was a litigation lawyer; there was no convincing him that he can continue to do what he loves with vocal fold paralysis and significant glottal insufficiency as a result.

### **Hearing your patient's complaint and observing your patient's voice**

As a consequence of our training and the need to practice medicine efficiently, we learn to focus our discussions with patients on the chief complaint. Appropriately, we devote time and attention to the main issue that brings a patient to us: sinus disease, cholesteatoma and its infectious complications, or concerns for malignancy.

On occasion, though, the complaint is less worrisome, and after counseling the patient regarding his or her concerns, we may have the time to take notice of the patient's voice. Our trained ears can pick up on roughness, or

maybe subtle pitch breaks. In those moments, we have the opportunity to say “Tell me again what kind of work you do.” Following up by inquiring about the voice and your patient's daily communication needs will bring comprehensive otolaryngologic care to your patient.

Many of our professional voice users are plagued by signs of vocal overuse and misuse. Acutely they may suffer from hemorrhage or inflammation; over time though, they can develop vocal fold nodules, polyps, cysts, and sulcus. If we are fortunate enough to identify the dysphonia and follow up by asking how it affects our patients, we may be able to prevent at least some of the consequences of chronic phonotrauma.

In-office laryngoscopy will provide a global picture, with the ability to identify overt pathology. However, when findings on flexible laryngoscopy do not adequately account for vocal quality, stroboscopy is necessary to fully evaluate vocal fold closure and vibratory characteristics. If equipment is unavailable to you, contact the speech-language pathologists with whom you collaborate. Even a short course of voice therapy with a voice-trained speech-language pathologist will help your patients explore their voices immeasurably.

”

### **Making use of speech-language pathologists, patient education, and voice therapy**

The speech-language pathologist's role in care of patients with voice issues is crucial. A voice evaluation with acoustic and aerodynamic analysis helps to uncover underlying tremor or spasm, glottal insufficiency, and muscle tension among other issues.

That done, and arguably more important, is the time spent with our patients to determine their own vocal awareness. Helping our patients to understand just how much they use their voices—speaking, teaching, preaching, or singing—is the professional voice user's “aha moment.”

Many of us take for granted the sometimes constant demands we place on our voice and then stress it further by using hands-free devices for phone conversations in the car, speaking louder when in a noisy restaurant, and cheering enthusiastically at our favorite sporting events. For those whose lives and livelihood depend on reliable vocal

quality, it is our responsibility to help them understand and care for their voice.

Once we have explored the amount of voice use our patient's profession requires, we can then focus on how to use the voice safely and efficiently. Voice therapy helps our patients develop awareness of the force and tension inherent in chronic phonotrauma. When properly applied, therapy can reverse some of the traumatic changes inflicted upon the vocal folds. It helps our patients prepare for surgical intervention when indicated. And then, therapy helps our patients recover from surgical intervention by making them more aware of breath support, resonance, volume, force, and the specific vocal needs for their profession. Finally, voice therapy enables some patients to use their voice confidently and efficiently despite persistent pathology.

**Promoting voice health and knowledge in the community**

We also have an opportunity to explore the voice of our patients on the level of our local

communities. Our colleagues providing primary care often hear our patients' voices before we do. And family members hear our patients' voices on a daily basis. With so many professions relying on the voice, it is an interest of community public health to promote vocal wellness. At your next local medical society meeting, discuss this importance and remind physicians to listen not just what their patients are saying, but how it sounds. Encourage them to reach out to you for further evaluation and care of dysphonia. Remind them of the importance of identifying not only malignancy and precancerous lesions but also benign pathology that still interferes with daily communication needs, quality of life, and in some instances professional livelihood.

As we all strive to provide comprehensive and quality otolaryngologic care, remember to explore the voice of your patients. ■

*I would like to thank Jeffrey P. Marino, MD, of the Ochsner Voice Center in New Orleans, LA, for his participation in preparing this article.*

Tips for patient care

**ENTs should consider**

- What is my patient's profession?
- Is the patient's voice integral to his or her performance?
- What are the vocal complaints?
- Is he or she a good candidate for voice therapy?
- Has he or she made progress with voice therapy?
- What are the medical and surgical treatment options?

**Primary care providers should consider**

- How long has the patient been dysphonic?
- What risk factors for head and neck cancer are there?
- What other symptoms are related? For example pain, dysphagia, dyspnea, otalgia, neck mass, etc.
- Is the patient's dysphonia affecting daily communication?

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# Explo



# WOR



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WWW





Want to offer your patients some timely advice on taking care of their voices for World Voice Day? Three AAO-HNS Voice Committee Members offer answers to questions you may hear in clinic

## **Q** If I have reflux and take my proton pump inhibitor, why am I still hoarse?

**A** **Salvatore J. Taliercio, MD, Sleepy Hollow, NY:** The interplay between reflux and voice is complicated. Laryngopharyngeal reflux (LPR), or “silent” reflux, presents clinically with a persisting globus sensation and throat clearing. The local effects of acid in the larynx are inflammatory, and can directly affect voice quality. Throat clearing results in trauma to the edges of the vocal cords, which can result in inflammatory lesions called granulomas, which then perpetuate the cycle of globus and urge to throat clear. Despite appropriate dietary changes, and adherence to proton pump inhibitors (PPI), patients with LPR can also present with subtle irregularities of the vibratory margins of the vocal cords. The changes are demonstrated dynamically through stroboscopy, which reveals glottic insufficiency that would explain poor voice quality.

**A** **Thomas L. Carroll, MD, Boston, MA:** The symptoms of glottic insufficiency can closely mimic those of LPR. Throat clearing and mucus sensation in the absence of globus sensation has been demonstrated in patients with vocal fold atrophy when LPR is not present based on impedance reflux testing. Considering a temporary diagnostic trial augmentation in this population before a long-term, high dose PPI trial may be worthwhile if the patient’s overall clinical history and exam does not solely suggest reflux changes but rather an elliptical or short phase closure pattern on stroboscopy. Other clues to consider glottic insufficiency rather than reflux as the etiology are supraglottic hyperfunction where one or both false vocal folds are covering the true vocal folds during sustained phonation. The hyperfunction is unlikely the primary problem but rather evidence of secondary compensation for underlying loss of air from the glottis.

## **Q** Will voice therapy fix my vocal cord nodules?

**A** **Dr. Taliercio:** Vocal cord nodules, or more broadly defined as vocal cord mid-membranous phonotraumatic lesions, are a common pathology for those with significant voice demands. Often those with nodules do not seek

treatment, as the patient has no limitations, despite a change in voice quality. For those with limitations, voice therapy serves as an instrument to improve vocal efficiency, to maximize the quality and production of voice given the patient's current laryngeal architecture. Therapy focuses on technique and awareness of voice use, and can even improve breath support. Ultimately, therapy may help to improve the appearance of nodules, but the primary goal is to reduce the patient's voice limitations and vocal fatigue, in a supportive fashion, that does not assume the risks of surgical intervention.

## Q What's new in the treatment of vocal fold paralysis?

**A** **Julina Ongkasuwan, MD, Houston, TX:**

Vocal fold medialization is one of the most rewarding procedures in otolaryngology. Injection laryngoplasty can now be done, transcervically or transorally in the office or at the bedside with a flexible nasolaryngoscope and video tower. The workhorse for long-term medialization remains type 1 thyroplasty; however, laryngeal reinnervation is experiencing resurgence in popularity.

## Q What can patients do to explore their vocal health?

**A** **Dr. Ongkasuwan:** Like many things in life, people do not think about their vocal health until there is problem; however, an ounce of prevention can go a long way. Resources exist through the Academy to learn about how the voice works. Especially for individuals for whom their voice is their livelihood, integrating vocal warm ups, using amplification, and incorporating opportunities to rest the voice can help protect the voice. In addition, vocal coaches are not just for singers, they can help people learn to project their voice in an efficient and atraumatic manner.

## Q What is new in the treatment of chronic epithelial lesions of the true vocal folds?

**A** **Dr. Carroll:** Office and operative treatment of recurrent respiratory papilloma

(RRP) and recurrent leukoplakia, including hyperkeratosis and dysplasia, has historically meant multiple trips to the operating room, voice change due to scarring of the lamina propria and progression of disease as patients are observed until "it is time to go back for another procedure". Office based KTP laser treatments can offer patients with RRP and other recurrent epithelial lesions maintenance procedures that do not require general anesthesia and loss of time from work. It is often necessary to start with an operative microsuspension laryngoscopy for diagnostic biopsies and complete lesion excision. After this, office-based surveillance and intermittent KTP laser ablation can maintain voice while keeping disease at bay. Patients prefer the lack of significant down time and the avoidance of a general anesthetic.

## Q What remains a difficult pathology to treat in the disordered voice?

**A** **Dr. Carroll:** Scarring of the lamina propria of the true vocal fold remains one of the most difficult laryngeal pathologies to treat. Vocal fold scar is variable in presentation and severity. Scar formation in the glottis

may be an active inflammatory process or more of a chronic result of an initial insult that leads to stiffness of the mucosal wave. Despite normal vocal fold motion, most patients with severe scar present with a harsh, strained, and effortful voice due to glottic insufficiency from inappropriate air loss and lack of normal vibratory characteristics. Some patients achieve a better functional outcome through voice therapy, however adjunct treatments are often necessary to achieve the patient's goals. Serial steroid injections into the scarred area of the vocal fold can soften the scar and modulate what may be an ongoing active inflammatory process. Surgery to excise the scar can be attempted but results are not always predictable. Placement of fascia or fat into the subepithelial plane of the true vocal fold has been demonstrated effective although also not completely predictable or longstanding. One consideration for otolaryngologists who face these difficult cases is to first consider a diagnostic trial vocal fold augmentation into the deep aspect of the vocal fold. Global injection augmentation does not intend to address the scar itself; rather it improves the glottic insufficiency and overall patient function. Research in the area of lamina propria replacement and modulation is ongoing. ■



**Michael M. Johns III, MD**

**WORLD VOICE DAY 2016**  
See AAO-HNS Voice Committee Chair Michael Johns' 2016 World Voice Day video promotion coming soon to [www.entnet.org/worldvoiceday](http://www.entnet.org/worldvoiceday).

# What is HCPLAN?

A network connector and idea aggregator, the Health Care Payment Learning and Action Network (HCPLAN) advances payment approach alignment across the private and public sectors of the health system

In 2015, the Department of Health and Human Services (HHS) set a goal of tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models (APM) by 2016 and 50 percent by 2018. HHS has also set a goal of tying 85 percent of all Medicare fee-for-service to quality or value by 2016 and 90 percent by 2018. As a part of this broader effort, HHS and stakeholders launched the Health Care Payment Learning and Action Network to advance alternative payment alignment across the private and public sectors of the health system. HCPLAN currently functions as a network connector and idea aggregator. The network accomplishes its goals through an online payment reform community called “Handshake,” in-person meetings, work groups, and white paper publication.

HCPLAN work groups are short-term groups charged with identifying and assessing the following: the main adoption barriers to alternative payment models; which of the main adoption barriers to alternative payment models can be addressed; creating a succinct outline of steps necessary to reach HHS’ goals; and motivating action toward sustainable APM development. Three work groups have been established: the Alternative Payment Model Framework and Progress Tracking Work Group; the Population Based Payment Work Group; and the Clinical Episode Payment Work Group. While no surgical specialties are represented within the HCPLAN network or work groups, the Academy is closely mon-

itoring the work group activities to review and comment on any proposals that would affect otolaryngologists.

## APM Framework White Paper

The first tangible cooperative effort created by the HCPLAN governing body is the Alternative Payment Models Framework White Paper drafted by the APM Framework and Progress Tracking Work Group.

In October 2015, HCPLAN released their draft APM Framework White Paper for comments. After taking into account the comments provided by the Academy and other stakeholders, HCPLAN released the final version of the white paper in January. The APM Framework White Paper outlines

a proposed working definition for alternative payment models and provides a rough trajectory for organizations wishing to transition from fee-for-service payments to a complete alternative payment model.

The Academy submitted comments on the draft APM Framework White Paper that reiterate our position that any alternative payment model framework must address the unique payment reform challenges faced by specialty physicians. Although surgical specialties are not currently represented in the established work groups and the APM Framework White Paper, the Academy is advocating on your behalf. We continue to work closely with our partners to ensure that any accepted APM framework will allow the largest possible numbers of physicians to not merely participate, but thrive within the framework’s constraints.

For more information on the future of payment and how payment reform could affect you, please visit the Academy’s payment reform information hub: [www.entnet.org/content/payment-reform](http://www.entnet.org/content/payment-reform). ■



The network accomplishes its goals through an online payment reform community known as “Handshake,” in-person meetings, work groups, and white paper publication.



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The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) is the world's largest organization representing specialists who treat the ear, nose, throat and related structures of the head and neck.

# CPT changes for 2016:

There are several Current Procedural Terminology® (CPT) code changes for 2016 applicable to otolaryngologist-head and neck surgeons. To assist Members, we have created the following summary of the changes that are relevant to otolaryngology-head and neck surgery. If you have any questions regarding CPT code changes for 2016, please contact the Health Policy team.

As the medical community has come to expect, part of the annual rulemaking process conducted by the Centers for Medicare & Medicaid Services (CMS) includes the annual issuance of new and modified CPT codes, developed by the American Medical Association's (AMA) Current Procedural Terminology Editorial Panel, for the coming year. In addition, CMS includes new, or updated, values (also known as relative value units [RVUs]) for medical services that have undergone review by the American Medical Association's Relative Update Committee (AMA RUC). CMS has the discretion to accept the RUC's RVU recommendations for physician work, as well as recommendations for direct practice expense inputs, or it may exercise its administrative authority and elect to assign a different value, or practice expense inputs, for medical procedures paid for by Medicare. The final value, as determined by CMS, is then publicly released in the final Medicare Physician Fee Schedule (MPFS) rule for the following calendar year.

The Academy is an active participant in both the AMA RUC valuation of otolaryngology-head and neck services and the CMS annual rulemaking processes. As part of those efforts, we want to ensure Members are informed and prepared for key changes to CPT codes and valuations related to otolaryngology-head and neck surgery services for CY

2016. The following outlines a list of coding changes, including new and revised CPT codes, as well as codes which were reviewed by the AMA RUC and could have modified Medicare reimbursement values for 2016.

## New Codes

In CY 2016, the following changes were made to CPT codes:

- **0406T**, *Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant*; and
- **0407T**, *Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; with biopsy, polypectomy or debridement*, were created.
- **92543**, *Caloric vestibular test*, was deleted.
- **92537**, *Caloric vestibular test with recording, bilateral; bithermal* was created
- **92538**, *Caloric vestibular test with recording, bilateral; monothermal* was created
- **92270** *Electro-oculography with interpretation and report*, new parenthetical references were added
- **92597**, **92605**, and **92607**, new parenthetical references were added
- **69209**, *Removal impacted cerumen using irrigation/lavage, unilateral*, was created.

(CPT Assistant article provides clarification on coding compared to **CPT 69210** and **E/M** services)

## Codes reviewed by the AMA RUC in CY 2015

In addition to the creation of several new CPT codes for 2016, a number of existing CPT codes relating to otolaryngology were reviewed by the AMA RUC, and their RUC approved values were submitted to CMS for final determination for the CY 2017 final rule. Members should be prepared for modified relative value units for some, or all, of these procedures in CY 2017. It is critical to note that 2016 is the first year where CMS will



begin publishing proposed values within the MPFS Proposed rule, typically published the first week of July. The Academy will monitor the recommended values for these services and comment on Members' behalf. Final values

# what ENTs need to know



will be released within the final MPFS, which is issued by CMS typically around November 1 of each year. Upon receipt, Academy health policy staff will summarize the final rule and alert Members to any critical changes in

reimbursement for any of the following medical procedures. Services that were reviewed included: caloric vestibular testing codes; laryngoscopy family of codes; and submucosal ablation of the tongue base. ■



## Top 100 ENT services for 2016

The Academy has prepared resources outlining the 100 most frequently reported CPT Codes by providers with subspecialty designation “4-Otolaryngology” within the Medicare enrollment database. Two charts are available: *2016 Top 100 ENT Codes Billed in a Physician Office* and *2016 Top 100 ENT Codes Billed in the Hospital Outpatient Department*. The *2016 Top 100 ENT Codes Billed in a Physician Office* document lists the 100 most frequently reported CPT Codes, by providers with subspecialty designation “4-Otolaryngology” within the Medicare enrollment database, for the physician office site of service. The *2016 Top 100 ENT Codes Billed in the Hospital Outpatient Department* chart includes a list of the 100 most frequently reported CPT Codes, by providers with subspecialty designation “4-Otolaryngology” within the Medicare enrollment database, for the hospital outpatient site of service.

Volumes for both charts are based on the most current claims data available, the 2014 Medicare claims data. Visit [www.entnet.org/content/top-100-ent-cpt-codes-2016](http://www.entnet.org/content/top-100-ent-cpt-codes-2016) to learn more and download the charts. ■





# Regent<sup>SM</sup> progress report

AAO-HSNF's first clinical data registry takes shape with pilot, quality measures, and governance

**W**e last provided a comprehensive update of Regent<sup>SM</sup> in the December/January *Bulletin* as part of the *AAO-HNS Annual Report*. In the past three months, the Foundation has made tremendous strides in the construction of Regent, including the recruitment of pilot sites, development of measures and the Regent data dictionary, and the creation of a governance structure. Additionally, the AAO-HSNF has filed with the Centers for Medicare & Medicaid Services (CMS) to allow practitioners to report quality data to CMS. We welcome this

opportunity to provide you a detailed update on Regent, the Otolaryngology Clinical Data Registry.

#### **Regent pilot**

The Regent pilot is officially underway and AAO-HSNF staff is working closely with our vendor, FIGmd, Inc., to orient and process 38 diverse sites that represent the depth and breadth of otolaryngology practice settings, including hospital-based practices, academic medical center practices, and private practitioners. This pilot phase is a critical step in the development of Regent and will enable the AAO-HSNF to test its performance

measures, ensure accuracy and reliability of extracted data, increase our understanding of practices' needs for educational tools and resources, and identify and solve any roadblocks encountered along the way. The pilot will also ensure that the appropriate technology architecture and practice support are in place prior to the full-scale launch of Regent.

In recruiting sites for our pilot, we had very specific needs for a diversity of sites and electronic health records (EHRs). The response to our recruiting efforts was overwhelming. The AAO-HNSF received a large number of requests and FIGmd recommended setting a limit of 35 to 40 site participants for the pilot. We deeply thank all of our Members for the overwhelming demonstration of support and commitment to Regent and look forward to working with each of you in the future.

Also, for Members who had their badges scanned as part of the Regent Miniseminar or at the Regent Booth at the 2015 AAO-HNSF Annual Meeting & OTO EXPO<sup>SM</sup>, and ex-

“

Quality reporting to CMS is just the first phase of the registry and measure development is now an ongoing activity.

”

pressed interest in the free one-year participation in Regent, we will be contacting each of you this spring—well before the Regent pilot concludes—with instructions and deadlines for securing this offer for the full launch of Regent in mid-2016.

#### Quality measures and Regent

Thanks to guidance from **Richard M. Rosenfeld, MD, MPH**, Performance Measures Task Force chair, **Lisa Ishii, MD, MHS**, former chair of the Registry Task Force and member of the Regent Executive

Committee, feedback from the Large Group Forum, AAO-HNSF, and input provided by **James C. Denny III, MD**, staff quickly refined the final list of Regent pilot measures and specified six new outcome measure options for our Members to utilize in Regent. Staff worked extensively with FIGmd to create the data dictionary of all required data elements to support the extraction and reporting of the measures in a registry environment. The final list of pilot measures includes 30 current PQRS measures and 12 non-PQRS measures. In addition to existing

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Your Annual Fund gift is a tax-deductible contribution that helps fund our mission in key areas, including: Education, Humanitarian and International Outreach, Regent<sup>SM</sup>/Clinical Data Registry, and the Legends of Otolaryngology campaign.

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otitis media with effusion (OME) measures, the non-PQRS measures comprise a new measure regarding the avoidance of intranasal corticosteroids for OME, as well as newly developed outcomes measures, including the resolution of OME after tympanostomy tube placement and four new tonsillectomy outcomes measures, addressing primary and secondary post-tonsillectomy hemorrhage in both children and adults. It is important to note that quality reporting to CMS is just the first phase of the registry and that measure development is now an ongoing activity. With the creation of the governance structure and seven advisory specialty groups, the goal is to have meaningful quality measures in place for our entire membership. Visit [www.entnet.org/regent](http://www.entnet.org/regent) to view the measures contained in Regent.

#### Quality reporting to CMS with Regent

AAO-HNSF staff also completed the required application materials and submitted to CMS to secure both Qualified Clinical Data

Registry and PQRS Qualified Registry Status for Regent. These materials were submitted in advance of the deadline of January 31, and included the provision of data validation plans, a series of attestations, a complete list of measures, and detailed specifications for each non-PQRS measure. The AAO-HNSF anticipates a response from CMS in early spring regarding the status of our application. Regent has also been constructed with the future in mind to support future measures reporting needs under the Merit-Based Incentive Payment System (MIPS) and other quality reporting programs.

#### Governance and oversight

The Executive Committee of the AAO-HNSF approved the governance structure and the appointment of the following individuals to the Regent Executive Committee:

- James C. Denny III, MD, chair
- William R. Blythe, MD
- Michael G. Glenn, MD
- Lisa E. Ishii, MD, MHS

- Melissa A. Pynnonen, MD
- Jennifer J. Shin, MD, SM
- Lauren S. Zaretsky, MD
- Robert H. Miller, MD, MBA, ex-officio

The Regent Executive Committee will have responsibility for strategic planning, priorities, and goal setting, while also monitoring the regulatory environment, governing the data contained in Regent, and overseeing quality improvement efforts. In the near term, it is anticipated that the Executive Committee will be actively involved in oversight of the Regent pilot and will be working to develop policies and procedures for critical aspects of Regent prior to its full launch in the summer of 2016.

We look forward to the future growth and development of Regent and to reporting pilot results before the AAO-HNSF Annual Meeting & OTO EXPO<sup>SM</sup> September 18-21 in San Diego. In the meantime, make sure to visit [www.entnet.org/regent](http://www.entnet.org/regent) to stay up to date. If you have any questions, please email [regent@entnet.org](mailto:regent@entnet.org). ■



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# CALL FOR PAPERS



*Otolaryngology-Head and Neck Surgery* is seeking papers relevant to **residency education in otolaryngology-head and neck surgery** for a themed issue to be published in spring 2017.

## Topics of Interest Include:

- Competitiveness of the residency application process
- Candidate evaluation, letters of recommendation, and references
- Diversity in candidate selection and achievement
- Relevant factors that contribute to successful applications
- Ongoing assessment of active residents, milestones, and objective performance evaluations
- Use of simulation activities in resident education
- Development of research activities among residents
- Success of residents in achieving fellowship and employment
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- Perceived mistreatment of residents

Submit papers for the themed issue at [www.editorialmanager.com/otohns](http://www.editorialmanager.com/otohns). Choose the manuscript classification "Residency Education Themed Issue" on the "Select Classifications" page when submitting. All article types are appropriate for submission.

**Deadline for submission to be considered for this themed issue is**

# November 1, 2016

*Accepted papers may be published in the themed issue or a standard issue at the Editors' discretion.*

If you have any questions, please contact the Editorial Office at [otomanager@entnet.org](mailto:otomanager@entnet.org).

 AMERICAN ACADEMY OF  
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# ENT PHYSICIAN

Sound Health Services, a twenty-three physician Otolaryngology group in St. Louis, MO, has an immediate opening in their South County practice. Sound Health Services is the largest independent ENT group in the St. Louis metropolitan area. We provide full service ENT care including Audiology, Vestibular Testing, Hearing Aid Dispensing, Voice & Swallowing Services, Facial Plastics and CT Scanning.



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- MD/DO from approved medical/osteopathy school
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- Graduation from accredited residency program in ENT

For more information about this position, please contact our Practice Manager, Rebecca Akers, at 314-843-3828, or by email at [bakers@soundhealthservices.com](mailto:bakers@soundhealthservices.com).

You may also visit our website at [soundhealthservices.com](http://soundhealthservices.com).

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Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.

This position will include both office and hospital settings.

**Requirements:**

- Board Certified or Eligible preferred
- MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
- Current Florida license
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**Contact Information:**

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**Otolaryngology - Inpatient Hospitalist**

The Department of Otolaryngology - Head & Neck Surgery at Emory University School of Medicine, Atlanta, GA seeks to add an Otolaryngologist at the rank of Assistant or Associate Professor with primary duties as Inpatient Hospitalist at Emory University Hospital. Duties will include Inpatient and Emergency Department consultation and continuing care during the normal scheduled work week. Opportunities for resident and fellow teaching and academic productivity are also available. A broad Otolaryngology base is required in order to handle urgent airway issues, invasive fungal disease and general consultation on complex and critically ill patients. Applicants must be Board Certified or Board Eligible and will have a University appointment. The practice currently consists of two part-time physicians covering all standard work days. Opportunity for additional outpatient practice can be arranged depending upon mutual interest.

*This position involves working with human blood, body fluids, tissues, or other potentially infectious materials.*

**Interested applicants should forward letters of inquiry and curriculum vitae to:**

**Douglas E. Mattox, MD**

William Chester Warren, Jr. MD, Professor and Chair  
Department of Otolaryngology – Head & Neck Surgery  
550 Peachtree Street, Medical Office Tower, Suite 1135  
Atlanta, GA 30308  
(404) 778-2525

[dmattox@emory.edu](mailto:dmattox@emory.edu)

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**POSITION ANNOUNCEMENT**

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Seattle, Washington**

The University of Washington Department of Otolaryngology-Head and Neck Surgery seeks candidates for a full-time generalist position with an interest in head and neck cancer as Assistant Professor without tenure (0113). This position would be a multi-year appointment with a 12-month service period. This position will have a high volume practice in all aspects of general otolaryngology and the opportunity to support subspecialty interest. Candidates should have a background and interest in clinical research that focuses on these areas critical to our specialty.

This position will be based at Harborview Medical Center and the Seattle Veterans Administration Hospital. The individual will function in a multi-disciplinary practice environment which includes fellow, resident, and medical student teaching and clinical or basic science research.

Minimum qualifications include an MD (or equivalent), certified or eligible for certification by the American Board of Otolaryngology, and eligible for a Washington State medical license. In order to be eligible for University sponsorship for an H-1B, graduates of foreign (non-US) medical schools must show successful completion of all three steps of the US Medical Licensing Exam (USMLE), or equivalent as determined by the Secretary of Health and Human Services.

**Send letter of interest and CV to:**

Neal D. Futran, MD, DMD  
University of Washington  
Oto-Head & Neck Surgery, Box 356515  
Seattle, WA 98195-7923  
[nfutran@uw.edu](mailto:nfutran@uw.edu)

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- Competitive salary, early partnership, health/dental insurance, 401k/Profit Sharing, paid CME and vacation.

*Interested candidates please forward letter of interest and curriculum vitae to Alice via email at [ccoops@comcast.net](mailto:ccoops@comcast.net).*



Arizona Otolaryngology Consultants is seeking to recruit a BC/BE fellowship trained Otolaryngologist- Neurotologist interested in joining a growing practice with an established referral base.

AOC, one of the largest single specialty groups in the Valley since 1997, is comprised of 13 physicians and 6 doctors of Audiology. Our group consists of multiple subspecialists, emphasizing all aspects of Otolaryngology/Head & Neck Surgery, including cochlear implant mapping, audiology services, hearing aid sales and CT scanning. We offer patients ease of access at any of our 5 office locations and many surgery options as a result of over a dozen hospital affiliations.

Our physicians are very active in the community and play an integral role in collaborative care. The selected candidate will have an opportunity to participate as a member of Barrow Neurological Institute's Skull Base Team, in addition to assisting in the development of Banner University Medical Center's Head and Neck Institute.

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602-476-5019 • [Alisons@aocphysicians.com](mailto:Alisons@aocphysicians.com)

For more information about our practice, please visit:  
[www.AOCPhysicians.com](http://www.AOCPhysicians.com).

## The Department of Otolaryngology at West Virginia University is seeking the following positions:

• **Fellowship-trained Head and Neck Surgeon** to join a well-established head and neck oncology service immediately. Applicants will have expertise with ablative and reconstructive procedures as well as trauma surgery. In addition to providing excellent patient care, the successful candidate will be actively involved in the teaching of medical students and otolaryngology residents. Opportunities are available for those interested in clinical/basic research. The department currently has 14 physician faculty members and fourteen residents in addition to an active NIH-funded research division with three PhD members.

• **A General Otolaryngologist** to expand our general otolaryngology & allergy services. The candidate would be expected to work in our main office as well as in one of our satellite offices. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

• **A board-certified Otolaryngologist Program Director** of the residency training program with 30% protected time, & the rest will be devoted for clinical services at the main campus. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

• **A Pediatric Otolaryngologist** to join a thriving academic practice. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

Successful candidates must also have an MD, MD/PhD or DO degree (the employer accepts foreign educational equivalent) and be eligible to obtain an unrestricted West Virginia medical license. Candidates must be board certified/eligible by the American Board of Otolaryngology. Faculty rank and salary will be commensurate with credentials.

U.S. News & World Report has ranked West Virginia University Hospitals #1 in the state for the last several years. WVUH provides the most advanced level of care available to the citizens of West Virginia and bordering states. Major expansion is underway to Ruby Memorial Hospital, adding a 10-story tower and an additional 114

licensed beds. WVU Medicine has also opened a three story, 110,000 square foot ambulatory care facility to help address the growing demand for services. The Robert C. Byrd Health Sciences Center has a full complement of academic programs in the clinical and basic sciences.

Morgantown is consistently rated as one of the best small metropolitan areas in the country for both lifestyle and business climate. The area offers the cultural diversity and amenities of a large city in a safe, family-friendly environment. There is also an excellent school system and an abundance of beautiful homes and recreational activities.

To learn more, visit [WVUMedicine.org/Careers](http://WVUMedicine.org/Careers) or submit your CV directly to:  
**Kelli Piccirillo, Physician Recruitment, at [piccirillok@wvumedicine.org](mailto:piccirillok@wvumedicine.org).**



For additional information, contact Dr. Hassan Ramadan, Professor and Chair, Department of Otolaryngology at [hramadan@hsc.wvu.edu](mailto:hramadan@hsc.wvu.edu) / 304-293-3233.

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UMass Memorial Medical Center is situated in Worcester, MA, a community rich in history. Worcester is the second largest city in Massachusetts and New England, and has a very large patient referral base. Worcester and the surrounding area have a strong and diverse economic base with family oriented communities and excellent school systems. Boston and Providence are only forty miles away, and beaches, lakes, and mountains are all easily accessible.

**For consideration and/or additional details, please submit your CV and Letter of Introduction to:**

Daniel Kim MD  
 Department Otolaryngology - Head and Neck Surgery  
 UMass Memorial Medical Center  
 c/o Melissa Miller, Physician Recruiter  
 Email: melissa.miller3@umassmemorial.org  
 Phone: 774-443-2980

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**Assistant or Associate Professor**

The Department of Otolaryngology - Head & Neck Surgery at Emory University School of Medicine, Atlanta, GA seeks to add a fellowship-trained Otolaryngologist at the rank of Assistant or Associate Professor with primary duties at the Atlanta Veterans Administration Hospital. Duties will include patient care, resident and fellow teaching, and academic productivity. Special skills in Head and Neck Oncology and/or Laryngology are especially sought. Applicants must be Board Certified or Board Eligible and will have a University appointment.

The current practice features one full-time Rhinologist, one part time Laryngologist, and one part time Otolologist. Two residents supported by an Advanced Practice Practitioner and a Patient Care Coordinator. Operating rooms are well equipped.

*This position involves working with human blood, body fluids, tissues, or other potentially infectious materials.*

**Interested applicants should forward letters of inquiry and curriculum vitae to:**

Douglas E. Mattox, MD  
 William Chester Warren, Jr. MD, Professor and Chair  
 Department of Otolaryngology - Head & Neck Surgery  
 550 Peachtree Street, Medical Office Tower, Suite 1135  
 Atlanta, GA 30308  
 (404) 778-2525  
 dmattox@emory.edu  
**\*\*EMAIL IS PREFERRED\*\***

*An Equal Opportunity / Affirmative Action Employer. Qualified minority male and female applicants are encouraged to apply. EOP # 34944BG*

# Full time Opportunity on Long Island (Port Jefferson, NY) as soon as June 1, 2016

**ENT and Allergy Associates, LLP (ENTA),** a collaborative practice of over 175 physicians in 42 offices throughout NY and NJ, is looking to add a board certified ENT to its rapidly expanding Long Island team. ENTA offers:

- ▶ A broad range of ENT, Allergy and Sub-Specialty Services
- ▶ A brand new state-of-the-art Port Jefferson clinical site, currently consisting of 7 ENTs and an Allergist
- ▶ A starting salary of \$300,000
- ▶ A well-traveled road to partnership without buy-ins and buy-outs

For more information, please visit [entandallergy.com/careers/physician-opportunities](http://entandallergy.com/careers/physician-opportunities) or [entandallergy.com/office/port-jefferson](http://entandallergy.com/office/port-jefferson) or contact:

**Robert P. Green, MD, FACS**  
 President, ENT and Allergy Associates  
[rgreen@entandallergy.com](mailto:rgreen@entandallergy.com)

**Robert A. Glazer**  
 CEO, ENT and Allergy Associates  
 914-490-8880 ■ [rglazer@entandallergy.com](mailto:rglazer@entandallergy.com)

# Full time Opportunity in Orange County (Middletown, NY) for a laryngologist as soon as June 1, 2016

**ENT and Allergy Associates, LLP (ENTA)**, a collaborative practice of over 175 physicians in 42 offices throughout NY and NJ, is looking to add a board certified/fellowship trained laryngologist to its rapidly expanding Hudson Valley team. ENTA offers:

- ▶ A broad range of ENT, Allergy and Sub-Specialty Services
- ▶ A state-of-the-art Middletown clinical site, currently consisting of 5 ENTs and an Allergist
- ▶ A starting salary of \$300,000
- ▶ A well-traveled road to partnership without buy-ins and buy-outs

For more information, please visit [entandallergy.com/careers/physician-opportunities](http://entandallergy.com/careers/physician-opportunities) or [entandallergy.com/office/middletown](http://entandallergy.com/office/middletown) or contact:

**Robert P. Green, MD, FACS**  
President, ENT and Allergy Associates  
[rpgreen@entandallergy.com](mailto:rpgreen@entandallergy.com)

**Robert A. Glazer**  
CEO, ENT and Allergy Associates  
914-490-8880 ■ [rglazer@entandallergy.com](mailto:rglazer@entandallergy.com)

## Do you have a position, course, or meeting you would like to promote?



The Bulletin is the perfect vehicle to reach your audience. Contact **Suzee Dittberner** today at **913-344-1420** or [sdittberner@ascendmedia.com](mailto:sdittberner@ascendmedia.com).



### Otologist/Neurotologist Massachusetts Eye and Ear

The Department of Otolaryngology at the Harvard Medical School is seeking an Otologist/Neurotologist with special interest in the vestibular system for a clinical and research faculty position at the Massachusetts Eye and Ear. An appointment at the level of Instructor, Assistant Professor or Associate Professor is anticipated, depending upon the level of the candidate's qualifications. The successful candidate must have completed fellowship training in the area of Otology/Neurotology or equivalent expertise, a track record of effective teaching, and is expected to be engaged in clinical, translational, and/or basic research in dizziness, balance or the vestibular system.

Please send inquiries, CV and letters of interest to:

**Steven D. Rauch, M.D.**  
Professor and Search Committee Chair  
Department of Otolaryngology  
Massachusetts Eye and Ear  
Harvard Medical School  
243 Charles Street, Boston, MA 02114  
Steven\_Rauch@meei.harvard.edu

The Massachusetts Eye and Ear and Harvard Medical School are Equal Opportunity/Affirmative Action Employers. Women and minorities are encouraged to apply.

### Otologist/Neurotologist FULL-TIME BE/BC FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for a full-time position. This job entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. UTMB Health is undergoing rapid growth as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. Additionally, the department operates a state of the art clinical vestibular laboratory established in collaboration with NASA. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country. Clinical research is encouraged but not mandatory.

Please direct your Letter of Interest and CV to:

**Vicente Resto, MD, PhD, FACS**  
Chair, Department of Otolaryngology, UTMB Health  
301 University Boulevard, Galveston, TX 77555-0521  
Email: varesto@utmb.edu Phone: 409-772-2701



UTMB is an equal opportunity, affirmative action institution which proudly values diversity. Candidates of all backgrounds are encouraged to apply.



### Head and Neck Surgery and Reconstruction Fellowship

The Department of Otolaryngology-Head and Neck Surgery in conjunction with University Hospitals Case Medical Center and the Seidman Cancer Center is proud to continue its competitive one-year Head & Neck Surgery and Reconstruction fellowship beginning July 2017. The head and neck surgical team includes **Drs. Pierre Lavertu, Rod Rezaee, Nicole Fowler and Chad Zender.**

#### This one year fellowship offers advanced training in:

- Microvascular free tissue transfer
- **Over 150 cases per year**
- Endoscopic and open skull base surgery
- Minimally invasive head and neck surgery
- Transoral laser and transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

#### Applicant requirements:

- Completion of an ACGME accredited Otolaryngology-Head and Neck surgery residency
- ABO board eligible or certified
- Ohio Medical license eligible

#### Fellowship requirements and opportunities include:

- Clinical duties
- Teaching residents and medical students
- 1-12 call
- Clinical or basic science research
- Participation in our resident microvascular course and skull base workshop
- Travel and presentation at national meetings
- Productivity bonus in line with a **competitive fellowship salary**

Please visit <http://uhhospitals.org/ENT> to view the position online and to submit CV for consideration.

For more information please contact:

**Chad Zender, MD, FACS**

Associate Professor • Director of Head and Neck Fellowship • Vice Chair of Clinical Affairs and Translational Research  
University Hospital-Case Medical Center • Department of Otolaryngology-Head and Neck Surgery  
Chad.Zender@UHhospitals.org • 216-844-5307

## A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology/ Head & Neck Surgery



### NEUROTOLOGIST/OTOLOGIST

- Rank commensurate with experience
- Excellent resources are available in this rapidly expanding program
- Fellowship training required

To apply and receive additional information about the support associated with this opportunity, please contact:

Stil Kountakis, MD, PhD, Professor and Chairman  
Department of Otolaryngology-Head & Neck Surgery  
1120 Fifteenth Street, BP-4109, Augusta, Georgia 30912-4060

Or email [skountakis@gru.edu](mailto:skountakis@gru.edu)



**AUGUSTA  
UNIVERSITY**

*Augusta University is an Equal Opportunity,  
Affirmative Action and Equal Access employer.*

## Incredible Otolaryngology Opportunity in SOUTHWEST ARIZONA

Seize this opportunity to establish and build an extremely successful practice in a growing community of 200k residents, with another 100k residents who join our community to play during our mild winters... and YES - in our 70 degree temperatures in February!

Flexible practice models exist, including a hospital employed position, a solo practice option, as well as the opportunity to join an existing practice already established in our community—completely your choice.

Yuma, Arizona sits on the edge of the Colorado River/Martinez Lake and the borders of California and Arizona and is located just under a 3-hour drive from San Diego, CA to the west and the same distance from Phoenix, AZ to the east.

Abundant recreational activities can be enjoyed all year in Yuma; boating, water skiing, kayaking, fishing, hiking, biking, hunting or camping to name a few.

Yuma Regional Medical Center (YRMC), a 406 bed top-in-technology facility, is the only acute care hospital of its size within a 170 mile radius and provides almost all modalities of



*Yuma, Arizona*

care. We boast a medical staff of over 400 physicians and allied health professionals across the majority of specialties, with more than 94% holding board certification.

Take advantage of this chance to earn EXCEPTIONAL income while enjoying a balanced and fulfilling personal life, all in a wonderful collegial environment—you will not be sorry you did!

**Contact me to learn more:**

**Pam Orendorff**

Director of Physician Relations & Recruitment

Phone: (928) 336-3032

Email: [porendorff@yumaregional.org](mailto:porendorff@yumaregional.org)



JOIN US IN SAN DIEGO, CALIFORNIA, FOR OUR  
AAO-HNSF 2016 ANNUAL MEETING & OTO EXPO<sup>SM</sup>



**AAO-HNSF**  
**ANNUAL MEETING**  
**& OTO EXPO<sup>SM</sup>**  
SEPTEMBER 18-21, 2016  
SAN DIEGO, CA

This invigorating, thought-provoking, and inspirational event showcases the latest advances in the specialty and exposes you to new research findings, approaches, and treatment options to help you deliver excellent patient care. In its 120th year, the AAO-HNSF Annual Meeting & OTO EXPO<sup>SM</sup> features all day cutting-edge education programming, dynamic evening events, and draws more than 5,500 otolaryngology, medical experts, and professionals from around the world.

As healthcare providers and otolaryngologist—head and neck surgeons, you owe it to yourself and to your patients to participate in the otolaryngology event of the year.

Visit [www.entnet.org/annual\\_meeting](http://www.entnet.org/annual_meeting)

# THE MORE DIFFICULT THE CASE, THE LESS DIFFICULT THE CHOICE OF HOSPITAL.



The Department of Otolaryngology – Head and Neck Surgery at The Mount Sinai Hospital is a world leader in the treatment of HPV-associated oropharyngeal cancers, using robotic surgery to deescalate therapy and reduce toxicity. We are widely recognized for our Facial Plastic and Reconstructive Surgery expertise, as well as our innovative Skull Base Surgery Center. Additionally, our experts are on the faculty of the Icahn School of Medicine at Mount Sinai, ranked among the nation's top 20 medical schools by *U.S. News & World Report*, and the Head and Neck Cancer Research Program is the foremost international resource for tumor dormancy.

- Head and Neck Institute
- Center for Hearing and Balance
- Center for Thyroid and Parathyroid Diseases
- Eugen Grabscheid MD Voice Center
- Skull Base Surgery Center
- Sleep Surgery Program



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