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

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FEBRUARY 2017
Volume 36, No. 01

The Bulletin (ISSN 0731-8359) is published 11 times per year (with a combined December/January issue) by the **American Academy of Otolaryngology—Head and Neck Surgery**
1650 Diagonal Road
Alexandria, VA 22314-2857
Telephone: 1-703-836-4444
Member toll-free telephone: 1-877-722-6467

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Postmaster: Send address changes to the American Academy of Otolaryngology—Head and Neck Surgery, 1650 Diagonal Road, Alexandria, VA 22314-2857
Return undeliverable Canadian addresses to PO Box 503, RPO West Beaver Creek, Richmond Hill, Ontario, Canada L4B 4R6
Publications Mail Agreement NO. 40721518

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BULLETIN ADVERTISING
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6710 West 121st St., Ste 100
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OTO News

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Have You Seen *OTO News*?

We have created more streamlined avenues for you to connect with your Academy and for your Academy to connect with you. *OTO News* is one of several communication tools we're premiering this year to provide you easy access to the latest news, updates, and resources within the specialty.

What You Need To Know:

- *OTO News* is a personalized e-newsletter created just for you
- Each issue is delivered straight to your inbox each Thursday
- *OTO News* is your one-stop-shop for all Academy and otolaryngology news
- Your Academy Dashboard features helpful membership information unique to you in each issue
- **Make *OTO News* Your Own!** Customize the content you receive using the personalized preference center.

Change and Plan B

"Change is the law of life. And those who look only to the past or the present are certain to miss the future."

—John F. Kennedy

Things change. Medicine changes. The Affordable Care Act represented change, and now that may change.

Change is ever-present and may sometimes require us going to Plan B. Change may represent something you applied for that didn't pan out or the deeper adversity of illness or accident, the loss of dignity, the sharp sting of prejudice, broken relationships, and sometimes even loss of life itself. In this, we need courage and to have faith and flexibility. The question is not if some of these things will happen to you, because they will; the issue is how you learn to deal with them. When we have unexpected complications in surgery, as we inevitably do, my discussion afterward with the typically downtrodden fellow and resident emphasizes that our commitment here is to learn from this complication and to do better next time—to change.

In all of this, we understand that our initial plan may not succeed, in which case we move to Plan B. Plan B represents a willingness to move with the change, to reshape yourself, and perhaps abandon your previous path to find a better path and a better plan for today.

When change presents itself, flexibility is our greatest ally. When I was a junior Member of our Academy, my very first Academy appointment, made by **KJ Lee, MD**, past Academy president and current Pacific Rim Regional Advisor, was to the Endocrine Surgery Subcommittee. The subcommittee had grown out of the task force from the overarching Head and Neck Oncology Committee. In the first few minutes of the meeting, the subcommittee chair announced that the work of the task force and subcommittee was completed, and they were now entertaining sunsetting the Endocrine Surgery Subcommittee. This was no more than one or two minutes into my time in the subcommittee appointment! I was not prepared for this change and frankly was panicked thinking that this committee, which I so desired to work on, was dissolving in front of my eyes. Time for Plan B! I stood up, apologized for making a comment being so junior on the subcommittee, and then respectfully articulated all the potential projects that this subcommittee could move forward with if allowed to exist. I described how committed I was to these projects and how important I thought endocrine surgery was to the future of our specialty. There was silence, and then the subcommittee chair, **W. Jarrard Goodwin, MD**, got up and said, "You know, you make some good points, Greg." The discussion ensued, the bullet dodged, and Plan B was engaged.

"Be yourself, everyone else is taken."

—Oscar Wilde

In later years, I chaired the Endocrine Surgery Subcommittee, and through the work of many, including **Robert A. Sofferman, MD, David J. Terris, MD**, and **Ralph P. Tufano, MD**, the subcommittee evolved to a full committee, is now a highly desirable committee to be appointed to, and has achieved such a level of functionality that it has been named a Model Committee. Flexibility in going with your own intuitive instincts is part of the adaptation toward acceptance of Plan B. Plan B comes from you.

Change and your Academy

The changes in medical bureaucracy, paperwork, and reimbursement will continue. We must not let this affect the quality of our patient care and our commitment to the profession we so love. Let the Academy help you with these changes.

Reach out to your colleagues through **ENTConnect,** perhaps the largest existing otolaryngologic-specific communication portal, at http://entconnect.entnet.org/home. Questions on medications, diagnostic and treatment inquiries, billing issues, and more can all be asked of our broader Academy otolaryngology community through ENTConnect.

Manage the future of your practice through the Academy's CMS-certified quality registry Reg-ent[SM]. Reg-ent now has nearly 1,800 registered participants and represents the largest otolaryngologic registry in the history of our specialty. Data rules, and our Academy, and we as Academy Members, now own our otolaryngology data through Reg-ent!

Change is a constant. Our Academy is prepared to walk with you through this changing landscape. Your Academy and I wish you a happy and healthy (and changing) 2017! ■

Gregory W. Randolph, MD
AAO-HNS/F President

> Plan B represents a willingness to move with the change, to reshape yourself, and perhaps abandon your previous path to find a better path and a better plan for today.

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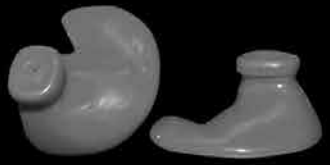

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Challenges and opportunities ahead

Following most elections in which a new administration and Members of Congress are seated, there is considerable discussion and anxiety over what changes will ensue. The current transition is particularly interesting given that we are in the middle of a major evolution in the healthcare delivery system that started with the previous administration. The Academy has always been and will be a non-partisan organization, following our mission to provide the best care for our patients. Our advocacy efforts will continue to be based on principles that answer the following questions. Will this benefit our patients? Will this benefit our members? Does this advance the quality, safety, and availability of medical care? We will work with a diverse group of colleagues, legislators, and regulators to improve the lives of our patients.

The most immediate changes will likely occur on the regulatory side. Organized medicine will be weighing in on a number of areas that could make the practice of medicine easier for providers. One area will be how clinical data is handled and shared to advance quality care in the future. There will also be opportunities on the legislative side at the federal and state levels as new priorities emerge. We are prepared to work for our members and patients on critical legislative efforts as changes unfold.

Quality and data

The drive toward quality and value within the private and public sectors is a non-partisan issue and will likely continue. We will have opportunities to help define how quality is measured and what should be measured. The rapidly expanding field of Patient Reported Outcomes (PROs) undoubtedly will be an important portion of the equation in the not-too-distant future. The Reg-ent℠ Executive Committee is studying the most appropriate way to incorporate this valuable input into our Clinical Data Registry, Reg-ent, early on so the necessary data will be available to our members by the time it is required.

The accumulation and sharing of appropriate clinically-based data across all specialties for the purpose of improving and standardizing care offers potential unlimited benefits to patients. However, as more specialty societies and other physician groups have committed to providing this platform through clinical data registries, a singular problem has arisen. The reluctance and/or refusal of major EHR vendors to share de-identified patient data is shaping up as a formidable obstacle to realizing the full potential of these registries to improve care on a nationwide basis. This is another tangible example of the failure to attain meaningful interoperability across multiple systems within the United States, and an issue that will need to be resolved over the next three to five years as part of any sort of national health policy. We are participating with many other medical organizations in trying to accomplish this goal.

Hearing aids

On December 7, 2016, the FDA announced a major change in policy regarding the sale of hearing aids. Consumers over the age of 18 will now be able to purchase hearing aids without a medical examination or the need to sign a medical waiver. The agency also indicated it will be commenting soon on the availability of basic over-the-counter hearing aids for patients with mild-to-moderate hearing loss. This ruling comes after months of discussions and position statements by the President's Council of Advisors on Science and Technology, the National Academy of Medicine, and testimony to the FDA by multiple stakeholders including the Academy. Concerns over the low utilization rate and expense of traditional hearing aids apparently led the FDA to prioritize access to more affordable devices for those with hearing loss. Unfortunately, by eliminating the need for a medical examination, the FDA has overlooked the "safety" component, and there will undoubtedly be patients with treatable hearing loss or potentially dangerous causes of hearing loss who are not identified—a point made by the Academy in direct testimony to the FDA. We feel it is incumbent on the FDA to mandate the inclusion of appropriate educational materials about treatable hearing loss in the packaging of these devices.

As we approach March 3, "World Hearing Day," we must continue to put patients first. It is critical for otolaryngologists to continue to educate the public, as well as other physicians treating hearing loss, as to the nature of these treatable causes of hearing loss and advocate for patients' ability to receive treatment for these diseases. As this new policy unfolds, the Academy will be working on a process to collect data as to the frequency that treatable causes of hearing loss are overlooked in this paradigm as well as to educate the public to warning signs that should signal the need for appropriate medical evaluation. ■

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

> "We are prepared to work for our members and patients on critical legislative efforts as changes unfold."

BOARD OF GOVERNORS

The BOG and the Leadership Forum

Stacey L. Ishman, MD, MPH
BOG Chair

What is the easiest way to get involved with the Academy? The Board of Governors (BOG)!

Who is the BOG?

The BOG was established in 1982 as the grassroots Member network within the Academy. It is made up of constituent societies—local, state, regional, and subspecialty/national groups—from around the U.S. and Canada and serves as an avenue of communication between the Members and the Board of Directors.

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Why should I get involved in the BOG?

This is a fantastic opportunity to connect with your colleagues and give us your input. The BOG has been home for private practice, hospital-employed, and academic physicians to meet and advocate regarding the socioeconomic and legislative issues that affect our practices. At the same time, we are a home for the general otolaryngologist, regardless of practice setting, to connect and help us prioritize the issues that are important to you. You do not need to have a formal position to be an active member.

How do I get involved?

- **Become an official representative to the BOG**. Every constituent society has three representatives, a governor, a legislative representative, and a socioeconomic and grassroots representative (www.entnet.org/bog under the virtual society resource center). Please check with your state society if you are interested in serving in one of those roles or check the website at www.entnet.org/bog to see who is representing you.

- **Apply to a BOG Committee**. We have three standing committees: Legislative Affairs, Socioeconomic and Grassroots, and Governance and Society Engagement.

- **Become a Regional Representative** (http://www.entnet.org/content/bog-region-map)

- **Become a State Legislative Tracker** (http://www.entnet.org/content/state-legislative-advocacy)

- Just **come to the meeting** or get in touch with me (stacey.ishman@cchmc.org). We are always looking for people who are interested in helping!

Where and when? The Leadership Forum, of course!

We will be discussing leadership skills, payment issues, legislative updates, MIPS, Reg-ent, cultural competency, and many more topics, including advocacy and society engagement, at the AAO-HNS/F 2017 Leadership Forum & BOG Spring Meeting, **March 10-13** in **Alexandria, VA**. At the same time, there are ample opportunities to **network with the leadership of our Academy** and ask questions directly to the candidates at the President-Elect Candidate's Forum. The meeting will also feature the BOG General Assembly, the ENT PAC Reception (for ENT PAC Leadership Club members), and **free CME credits.**

Involvement of local, regional, and state society administrators and society presidents

This year for the first time, we are also excited to be engaging local, regional, and state society administrators and presidents to exchange ideas on the best way to run a society and benefit from AAO-HNS resources. This meeting will take place on **Friday, March 10, 2017**, and anyone involved in these societies is free to attend. Please contact us at (bog@entnet.org) if you are interested in involving your society. I hope to see you there. ■

AAO-HNS/F 2017
LEADERSHIP FORUM & BOG SPRING MEETING
MARCH 10-13
ALEXANDRIA, VA

Join leaders of the specialty, and register for the AAO-HNS/F 2017 Leadership Forum & BOG Spring Meeting, March 10-13, in Alexandria, VA. Visit www.entnet.org/leadershipforum for additional information and to register today!

Call for 2017 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 March 11, 2017, by the Executive Committee of the Board of Directors. The recipient will be recognized during the 2017 Annual Meeting & OTO Experience in Chicago, IL. Deadline for submission of the nominee form is March 1, 2017. Please visit our website, **http://www.entnet.org/content/jerome-c-goldstein-md-public-service-award**, for more information. ■

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AAO-HNS/F 2017

LEADERSHIP FORUM & BOG SPRING MEETING

MARCH 10-13

ALEXANDRIA, VA

Registration Is Open!

Registration Deadline: Wednesday, March 1, 2017

Join your colleagues for a weekend of leadership discussions, Board of Governors (BOG) meetings, informative speakers, advocacy updates, and mentoring/networking opportunities! This meeting is one of many AAO-HNS benefits, allowing Academy Members the opportunity to network and engage in peer-to-peer interaction with eminent leaders.

Registration is required and is free for AAO-HNS Members who are otolaryngology practitioners.

The Westin Alexandria Hotel
400 Courthouse Square
Alexandria, VA 22314

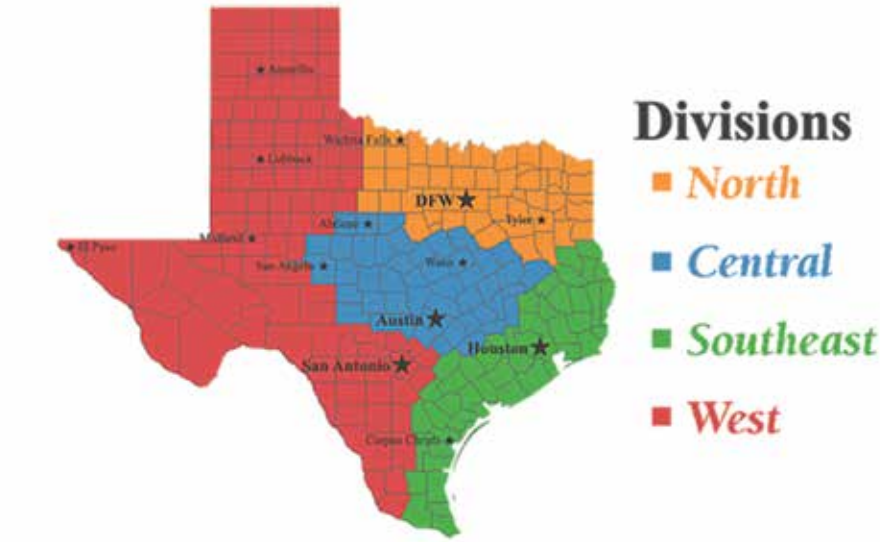
For registration, housing, and additional information – www.entnet.org/leadershipforum

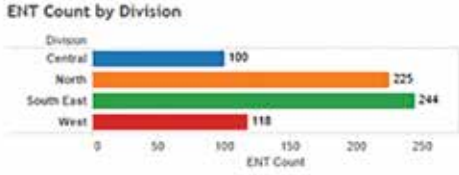
Questions? Contact BOG@entnet.org

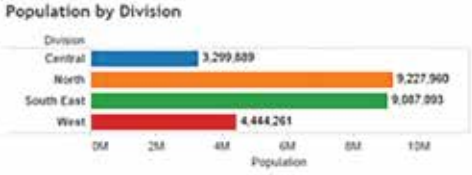
PRACTICE PROFILE

North Texas Ear, Nose & Throat Associates, PA

206 physicians serve patients across the state of Texas







"What makes NTENT unique is that it is both a physicians' group and a professional association, which was created under Texas statute.[1] I am not aware of any other state having something like what we have created here in Texas," said **Dwight A. Lee, MD**, the current statewide medical director and chair of the NTENT Medical Directors' Committee.

Dwight A. Lee, MD

North Texas Ear, Nose & Throat Associates (NTENT) was established in 1995 with a shared vision by eight otolaryngologists who joined together in response to changing market forces in Dallas, TX. Dr. Lee, together with co-founder **John Moore, MD**, grew NTENT to almost 100 members by 2013. Initially, all the member physicians were geographically located in the Dallas-Fort Worth metroplex.

In the spring of 2014, NTENT leadership looked to further support its members in navigating the current and future healthcare landscape by expanding both geographic area and specialty coverage. NTENT now includes a statewide executive committee and five separate divisions—southeast, central, western, north, and the specialty of oculoplastics—with each division having its own board and medical director. NTENT has a current membership of 206 physicians and serves an estimated population of about 17 million patients, with many of those patients coming from four areas in the state:

> Some of the other benefits offered to members of NTENT include direct contracting with all large carriers, optimized reimbursement, credentialing, claim support, access to designated carrier representatives, physician incentive opportunities, current legislative updates, and analytical reporting.
>
> **Dwight A. Lee, MD**

Dallas-Fort Worth, Houston, Austin, and San Antonio.

"Even though we have expanded in number and in scope, our goal has always been the same—bringing together the highest quality physicians for the best patient outcomes. This is what drives NTENT," said Dr. Lee.

"Last August, the SullivanLuallin Group performed NTENT's patient satisfaction survey, with over 4,700 patients statewide participating. The survey results confirm that NTENT is scoring higher in all six standard categories than the national average for otolaryngologists," Dr. Lee said. "This reflects our ongoing commitment to patient satisfaction and care, to monitoring our performance, and to continually improving the delivery of healthcare. That focus is the core of our vision and mission.

"In addition to a focus on quality care, we have helped our members save money through group purchasing of malpractice insurance and hearing aids. We are striving to expand these offerings with our increased purchasing power while seeking more ways to create and provide value to our membership base," explained Dr. Lee.

"Some of the other benefits offered to members of NTENT include direct contracting with all large carriers, optimized reimbursement, credentialing, claim support, access to designated carrier representatives, physician incentive opportunities, current legislative updates, and analytical reporting."

NTENT is currently implementing its 2014-2018 business plan, which includes the creation of a database depository, another significant offering to their members. "Prior to the Academy's 2015 Annual Meeting, we experienced a problem with the development of our database, and the progress on our business plan was slowed," said Dr. Lee. "At the annual Academy meeting in Dallas, I was introduced to Reg-ent℠. Reg-ent came along at absolutely the best possible time because it provided a solution to jump-start our data acquisition. Since then, the NTENT Board approved a switch to Reg-ent, and we have been working closely with Academy staff to ensure we are well on our way to reach most of our goals by 2018."

Dr. Lee has been a Member of the Academy since 1982 and has been involved in several leadership roles throughout the years, including the Board of Governors and its Executive Committee and The Health Policy Commission. "Being connected to the Academy has been a great experience, not only on a personal level but also at a national and professional level. I have great faith in the people and the work of the Academy to support our specialty. The Academy provides so much related to practice management that there is no other way to put it than to say the Academy is the glue that holds otolaryngologists together." ■

Reference

1. http://www.statutes.legis.state.tx.us/Docs/BO/htm/BO.301.htm

Reg-ent℠: the right registry at the right time

The AAO-HNS/F's Reg-ent is an otolaryngology-specific clinical data registry that is becoming the foundation for quality reporting, quality indicators, quality improvement, clinical and product research, and support for maintenance of certification and licensure. Participating otolaryngologist-head and neck surgeons may access the data and run queries on their own patient population to create practice reports and to benchmark practice performance and uncover potential areas for quality improvement. Results can also be benchmarked to the overall aggregated data.

As the state-wide medical director for NTENT, **Dwight A. Lee, MD**, will be traveling throughout Texas to integrate data from individual member practices into the Reg-ent software. "It will be a lot of travel, and there may be challenges along the way, but this is a necessary step to support our members in ensuring their data is vetted and is correct," he said. "I am really excited about Reg-ent and how it will support NTENT in our efforts to support our members in extracting common data, transitioning to the new payment system, and supplementing our mission and vision for quality patient care."

"Because of Reg-ent, NTENT is in the perfect position to help our members and serve as a repository of information with the new payment system. We will be able to coalesce all the necessary steps to help our practitioners transition to MIPS through our data engagement with Reg-ent. NTENT serves as the local and regional market resource for our members who are further supported by the national reserves of information that the Academy provides," said Dr. Lee.

Reg-ent can help otolaryngology practices of any size. Find more information on Reg-ent and how it can help your practice at **http://www.entnet.org/regent.** ■

Frequently asked questions on MIPS reporting in 2017

On January 1, 2017, eligible clinicians (ECs) could begin reporting for the Merit-based Incentive Payment System (MIPS) program. Under MIPS, ECs will report on multiple categories and receive a composite performance score (CPS). The Academy has received several inquiries from Members asking about the MIPS program and how they can report in 2017. In response to these questions, the Academy has put together a frequently asked questions document to help Members.

Q Who participates in the MIPS program and how do ECs enroll?

A All physicians, physician assistants, nurse practitioners, clinical nurse specialists, or certified registered nurse anesthetists who bill Medicare must participate in MIPS, **unless** they

- Qualify for an exemption,
- Do not meet the minimum reporting threshold, or
- Are part of an Advanced Alternative Payment Model (APM).

For the 2017 reporting period, ECs are automatically enrolled in MIPS. CMS will use a combination of an EC's NPI and TIN to determine the 2017 MIPS score.

Q What are the MIPS categories ECs will report on and how will CMS use these to calculate a score?

A In 2017, CMS will base an EC's CPS on reporting from three categories: Quality, Advancing Care Information (ACI), and Improvement Activities. CMS will use the scores for each category, add them together, and compare it to a pre-determined threshold to assess if an EC will receive a positive or negative payment adjustment.

Q How do ECs avoid a four percent reduction in Medicare payments in 2019?

A Under MIPS, ECs who do not qualify for an exemption, do not meet the minimum reporting threshold, or are not part of an Advanced APM can choose to report under the test pace in 2017. Under this, ECs are only required to submit either one quality measure, one improvement activity, or four to five of the required Advancing Care Information (ACI) measures to avoid a four percent reduction in Medicare payments in 2019.

Q Where can Academy Members find resources to learn more about MIPS reporting?

A The Academy has created a webpage to help Members navigate MIPS reporting in 2017 and beyond. All Academy materials including fact sheets, comment letters, and links to other resources can be found at **http://www.entnet.org/content/mips.**

To learn more about each category and the default weights for the 2017 reporting/2019 payment period, please review the Academy's fact sheet on MIPS, which is available at **www.entnet.org/MIPS-facts.**

To learn more about the reporting options available to ECs in 2017, please refer to the Academy's fact sheet on the CMS reporting option announcement, which is available at **www.entnet.org/2017-reporting.**

Additionally, CMS posted an interactive web page on MIPS reporting for 2017, including an interactive tool to help ECs choose applicable measures for reporting. For this tool and other helpful resources, please visit **https://qpp.cms.gov/measures/performance.**

Q How can Reg-ent℠ help Academy Members report under MIPS?

A The AAO-HNSF Reg-ent℠ registry is planning to offer Quality, Improvement Activities, and ACI reporting for Reg-ent practices in 2017. If you would like to learn more about Reg-ent, please visit **www.entnet.org/regent.** There you will find information on the EHRs with which Reg-ent can connect, in addition to pricing and other resources to help you get started. Members can click on the "Get Started Now" button on the Reg-ent home page to join the Reg-ent registry. If you have further questions, please email **regent@entnet.org.** ■

The first 100 days

What to expect from the new Administration and 115th Congress

> 2017 is poised to be a whirlwind year, with many AAO-HNS priorities potentially addressed and/or referenced in the context of broader healthcare-related dialogue.

After a hyper-partisan campaign season and some November election surprises, the dust slowly began to settle on Capitol Hill in late 2016. During that time, President-elect Trump's "Transition Team" arrived in the nation's capitol and both chambers of Congress, without much fanfare, reaffirmed their respective leadership. Then, the planning began. Read on to learn more about the issues the new Administration and Congress are likely to address early this year.

Repeal of the Affordable Care Act

Republicans have long sought to repeal and replace one of the Obama Administration's signature achievements, the Affordable Care Act (ACA), voting more than 60 times on various repeal measures since the bill became law in 2010. That goal is now likely to become reality, with questions about IF the ACA will be repealed changing to questions about WHEN the measure will reach President Trump's desk. Despite the general consensus that Congress will move quickly to advance a comprehensive repeal bill, Republican lawmakers have continued to struggle with the last, and most important, question, WHAT will replace the ACA? The "with what" associated with ACA repeal does not seem to be a question that will be answered easily. Stay tuned as this repeal/replace effort continues to unfold.

Regulatory relief

Easing the "regulatory burden" is another top priority for Congress and the new Administration. As such, both entities are expected to focus on rolling back several regulations that were finalized in the final months of the Obama Administration during the first part of the year. Per the Congressional Review Act, Congress can utilize a 60-legislative-day "look-back" at any new federal regulation issued by government agencies and, by passage of a joint resolution, can overrule said regulation. Preparations to utilize this procedural review tactic were well underway late last year and even impacted Congress' desire to adjourn as quickly as possible in December. While this effort will not specifically focus on healthcare, it remains possible that several health-related regulations could be impacted.

Tax and entitlement reform

Although any efforts relating to tax and entitlement (Medicare/Medicaid) reform may fall beyond the 100-day mark, they remain among the most talked-about issues. Whether Congress and the Administration attempt to quickly tackle these issues will largely depend on their strategies regarding usage of the budgetary tactic known as reconciliation. Given their slim majority in the U.S. Senate, Republicans would likely fail to achieve the 60 votes necessary to advance legislation under regular order. However, the budget reconciliation process would allow Republicans to pass legislation with only 51 votes.

The bottom line is that 2017 is poised to be a whirlwind year, with many AAO-HNS priorities potentially addressed and/or referenced in the context of broader healthcare-related dialogue. To remain current on these and other issues impacting the specialty, AAO-HNS Members are encouraged to join the ENT Advocacy Network by emailing govtaffairs@entnet.org. For information regarding the Academy's legislative advocacy efforts and priorities, contact **legfederal@entnet.org.** ■

Leaders of the PAC

The ENT PAC Board of Advisors thanks our Leadership Club Investors for their generous support to ensure the specialty has a powerful voice on Capitol Hill. With your support, otolaryngology-head and neck surgery is guaranteed a seat at the table on issues impacting our profession, our practices, and our patients. View the full 2016 list of contributors, including categories for the General Member, Practice Investors, and AAO-HNS staff, online. Program year: January 1, 2016 through December 31, 2016

ENT PAC

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WIO Endowment opportunities

The Women in Otolaryngology (WIO) Endowment was established in 2010 with the generous donations of many forward-thinking men and women who understood the challenges that women in otolaryngology-head and neck surgery face. The idea of an endowment to provide a perpetual stream of earnings, which could be used to address and eliminate the obstacles to career success, struck a chord with many. Within a very short period, donations to the WIO Endowment reached more than $400,000, and it continues to grow through ongoing donations. In fact, today it is the AAO-HNS Foundation's third largest endowment fund.

Donations to an endowment become the "corpus" and are not, as such, ever spent. Rather, the corpus is to generate a perpetual stream of earnings. This is where it gets exciting! Investment earnings are used to fund the programs and initiatives outlined in the endowment's charter: specifically, **career development** of women otolaryngologist-head and neck surgeons, **actionable research** that affects how women are integrated into mainstream otolaryngology, **unique approaches to work/life integration, leadership development** and recognition, and engagement of **inspiring, informative speakers** relevant to women's needs and interests for WIO Section meetings and functions.

Currently, the WIO Endowment, corpus and earnings, totals almost $500,000. The WIO Endowment Committee, charged with growing the endowment corpus through fundraising, also identifies projects and research to be funded with investment earnings that support the professional development of women in otolaryngology. Those the WIO Endowment Committee identify as meritorious are then recommended to the WIO Governing Council for approval.

Although women in otolaryngology-head and neck surgery face challenges that include pay inequity, barriers to leadership advancement, and work/life balance pressures, these challenges present the opportunity for all of us to work together to ensure that the current generation and future generations of women

in otolaryngology do not face these struggles. Issues that affect some of us also affect the entire otolaryngology community to various degrees. The entire community of otolaryngology-head and neck surgery, working together, can help to shape an inclusive future for all otolaryngologists. Acknowledge your concern regarding theses issues, whether for yourself or someone you know, by donating to the WIO Endowment. Donations of any amount are welcomed and greatly appreciated.

If you are interested in donating to the WIO Endowment or have questions, please contact Marylou Forgione at **mforgione@entnet.org** or 703-535-3775. Donations of any amount are welcomed and appreciated.

Applications for the WIO Endowment Grants are currently open through April 7, 2017. Up to $13,000 in grant funding will be awarded. To apply for a WIO Endowment grant, go to **http://www.entnet.org/content/women-otolaryngology-section.** ■

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mENTorConnect is designed to help bring AAO-HNS Members together to provide a unique opportunity for personal and professional growth through the creation of mentor relationships. With mENTorConnect, it's easier than ever to find other Members and share your knowledge, wisdom, and experiences, as well as invest in the next generation of our specialty. Visit **www.entnet.org/mentorconnect** to get started with mENTorConnect today! ■

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Examining diversity in the AAO-HNS

Valerie A. Flanary, MD, Diversity and Inclusion Committee Chair

Diversity and inclusion, as well as cultural competency, are now well-known focuses in most organizations and institutions. Studies have proved that diverse work places and environments lead to increased productivity, creativity, and overall success in the workplace. Our Academy is striving to define our diversity and inclusion as well as create a strong element of cultural competency. Cultural competency can be defined as a set of behaviors, policies, and attitudes that allows cross-cultural groups to effectively work professionally in situations, ensuring individuals are competent to function on their own and within an organization where multicultural situations will be present.[1]

The Diversity and Inclusion Committee was established to investigate and improve diversity and inclusion within the Academy as well as to assist Members in becoming more successful in treating diverse patient populations. This past summer we surveyed our Members to determine our cultural competency as an organization. Unfortunately, we had only a five percent response rate. However, we do wish to share these results with our Members.

The following results are simply the beginning of our journey for diversity and improved cultural competency. With these results in mind, we will work on revising and resending the survey prior to the 2017 Annual Meeting, September 10-13, in Chicago, IL. Hopefully, the new results will help advance the Academy and improve our diversity, inclusion, and the understanding of its importance in the practice of otolaryngology.

Highlights of the 2016 Cultural Competency in Otolaryngology Survey

Demographics:

- 77% of respondents were male
- 82% of respondents were white
- 60% of respondents believe we are a somewhat diverse organization
- 29% of respondents believe we are a very diverse organization
- 10% of respondents believe the Academy is not diverse
- 75% perceive the Academy to have adequate demographic representation
- Less than 1% believe the Academy is not culturally competent

Training:

- 46% of respondents have had some diversity training
- 75% believe diversity and inclusion should be incorporated in medical school education
- 50% believe that having a similar background helps the patient-physician relationship
- 46% have participated in scholarly activity regarding health disparities
- Less than 50% are likely to attend diversity or cultural training seminars or activities
- Most respondents were willing to pay no more than $75 for a CME course on diversity

Full survey results can be reviewed at **http://entconnect.entnet.org/viewdocument/cultural-competency.**

Conducting this survey of the membership and sharing the results is only the first step in shaping an essential dialogue to drive greater diversity, inclusion, and cultural competence within our Academy. Please consider this information to further your engagement in the discussion to move us to the next phase of this crucial endeavor. ■

Reference

1. http://www.businessdictionary.com/definition/cultural-competency.html

AAO-HNS/F Seeks Chair for Ethics Committee

AAO-HNS/F Boards of Directors are seeking applications for the position of Chair of the AAO-HNS/F Ethics Committee. The chair-elect would serve from October 1, 2017, through September 30, 2018, then as chair for a term of four years beginning October 1, 2018, with a possible two-year extension at the discretion of the Executive Committee.

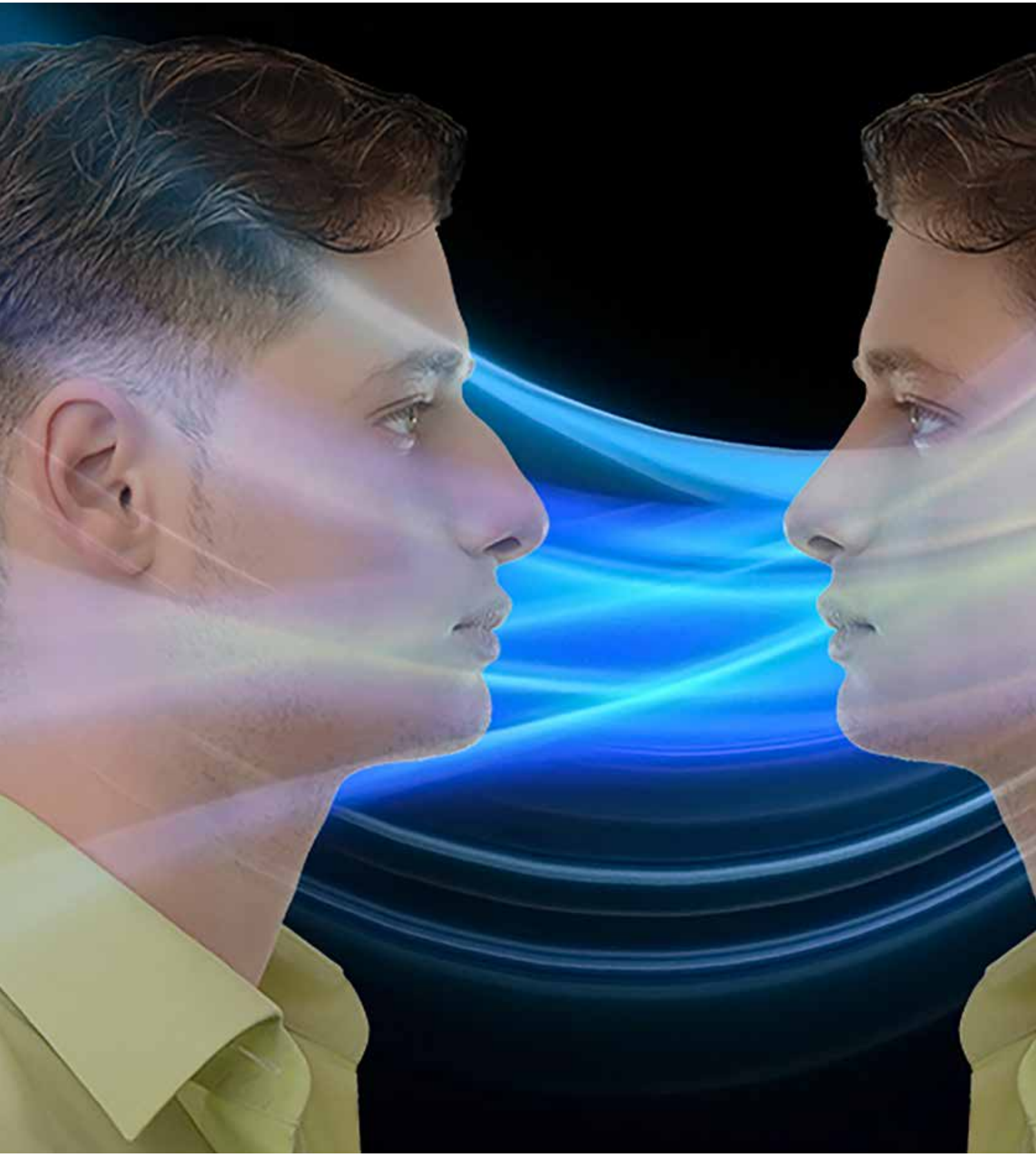
The Ethics Committee assists the Boards of Directors in fulfilling their oversight responsibilities with respect to (1) development and enforcement of the Code for Interactions with Companies and the Code of Ethics; (2) the management of potential conflicts of interest; (3) the oversight of policy recommendations regarding ethical issues to the Boards of Directors for their action; and (4) upholding the procedural guidelines for the AAO-HNS disciplinary proceedings.

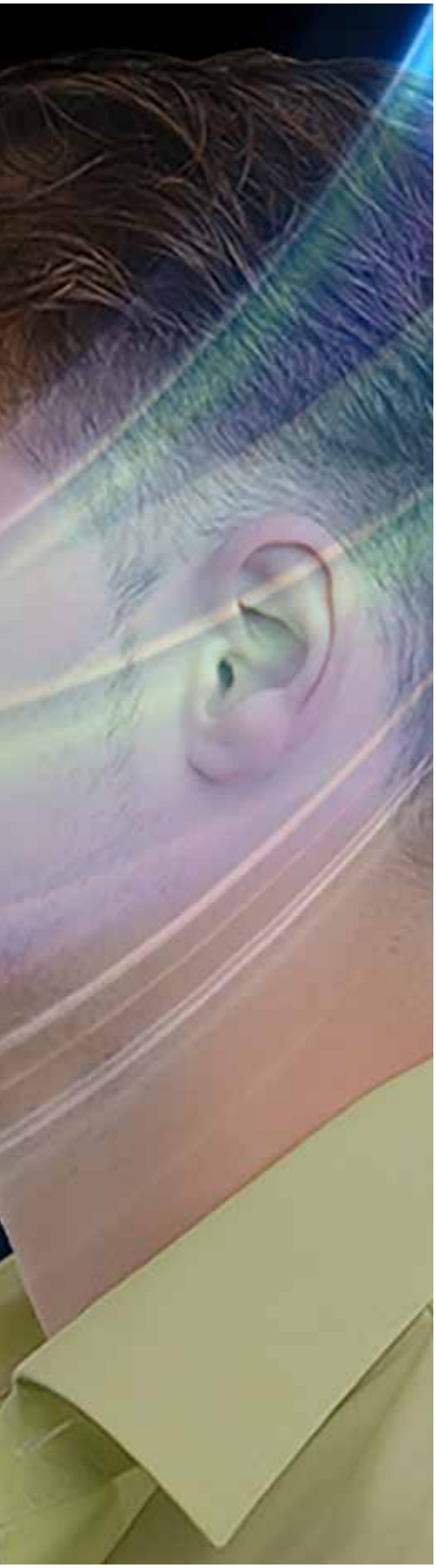
The ideal candidate will be a practicing otolaryngologist who has served or is serving on the Ethics Committee.

For more information about the position and a detailed job description, visit **http://www.entnet.org/sites/default/files/chair_ethics_committee_jd.pdf** Interested candidates should submit a CV and cover letter to Pamela Wood at **pwood@entnet.org** by March 31, 2017. ■

NYU team provides surgical care in Haiti

Dylan Francis Roden, MD, MPH, and a group of 10 from New York University (NYU) worked alongside Haitian surgeons, nurses, surgical technicians, and anesthetists for a week in September 2016 performing surgeries for compressive goiter, dermoids, papillary thyroid cancers, and salivary gland tumors at Hopital Sacre Coeur, in Milot in northern Haiti. The NYU team helped teach surgical techniques, intubation strategies, efficiency in operating room utzilization, and postoperative care practices. They left Haiti days before Hurricane Matthew hit southern Haiti. Fortunately, the 125-bed Hopital Sacre Coeur was relatively protected from damage.





CLINICAL PRACTICE GUIDELINE

Improving Nasal Form and Function after Rhinoplasty

Adapted from the February 2017 Supplement to ***Otolaryngology–Head and Neck Surgery***. Read the guideline at **otojournal.org**.

The primary purpose of the "Clinical Practice Guideline: Improving Nasal Form and Function after Rhinoplasty" is twofold: 1. to fill the current void of multidisciplinary clinical practice guidelines available to clinicians and patients and 2. to provide evidence-based recommendations for clinicians, who either perform rhinoplasty or are involved in the care of a rhinoplasty candidate, to optimize patient care, promote effective diagnosis and therapy, and reduce harmful or unnecessary variations in care.

The 2017 guideline was chaired by **Lisa E. Ishii, MD, MHS**, with **Travis T. Tollefson, MD, MPH**, and **Gregory J. Basura, MD, PhD**, serving as assistant chairs, and **Richard M. Rosenfeld, MD, MPH**, as the methodologist.

"Rhinoplasty ranks among the most commonly performed cosmetic procedures in the United States, with over 200,000 procedures reported in 2014," said Dr. Ishii. "And prior to these guidelines, limited literature existed on standard pre- and post-management care for patients undergoing this procedure. These guidelines are crucial in building unanimity regarding the peri- and post-operative strategies to maximize patient safety and optimize surgical results for patients."

This is the first evidence-based clinical practice guideline developed to address rhinoplasty with the goal of providing clinicians, and those involved in the management of these patients, with a logical framework to improve patient care by using a specific set of focused recommendations based upon an established and transparent process that considers levels of evidence, harm-benefit balance, and expert consensus.

"We are particularly delighted to have had input and collaboration from all stakeholders to develop guidelines that emphasize both form and function when performing rhinoplasty," said Dr. Ishii.

The guideline is endorsed by the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), American Society of Plastic Surgeons (ASPS), American Academy of Sleep Medicine (AASM), American Rhinologic Society (ARS), Society of Otorhinolaryngology and Head-Neck Nurses (SOHN), American Society for Aesthetic Plastic Surgery (ASAPS), American Academy of Pediatrics (AAP), and The Rhinoplasty Society.

The full guideline as well as other resources are available at **http://www.entnet.org/rhinoplastyCPG** and in *Otolaryngology–Head and Neck Surgery* as published at otojournal.org.

The guideline is intended for any clinician or individual, in any setting, involved in the management of patients of rhinoplasty. The target patient population is all patients age 15 years and older. The guideline is intended to focus on knowledge gaps, practice variations, and clinical concerns associated with this surgical procedure, and is not intended to be a comprehensive reference for improving nasal form and function after rhinoplasty.

Guideline recommendations

Communicating expectations

Clinicians **should** ask all patients seeking rhinoplasty about their motivations for surgery and their expectations for outcomes, should provide feedback as to whether those expectations are a realistic goal of surgery and should document this discussion in the medical record.

Comorbid conditions

Clinicians **should** assess rhinoplasty candidates for comorbid conditions that could modify or contraindicate surgery that include obstructive sleep apnea, body dysmorphic disorder, bleeding disorders, or chronic use of topical vasoconstrictive intranasal drugs.

Nasal airway obstruction

The surgeon, or the surgeon's designee, **should** evaluate the rhinoplasty candidate for nasal airway obstruction during the preoperative assessment.

Preoperative education

The surgeon, or the surgeon's designee, **should** educate rhinoplasty candidates regarding what to expect after surgery, how surgery might affect the ability to breathe through the nose, potential complications of surgery, and the possible need for future nasal surgery.

Counseling for obstructive sleep apnea patients

The clinician, or the clinician's designee, **should** counsel rhinoplasty candidates with documented obstructive sleep apnea (OSA) about the impact of surgery on nasal airway obstruction and how OSA might affect perioperative management.

Managing pain and discomfort

The surgeon, or the surgeon's designee, **should** educate rhinoplasty patients before surgery about strategies to manage discomfort after surgery.

Outcome assessment

Clinicians **should** document patient satisfaction with their nasal appearance and with their nasal function at a minimum of 12 months after rhinoplasty.

The guideline development group *recommended against* certain actions. These include:

Postoperative antibiotics

When a surgeon, or the surgeon's designee, chooses to administer perioperative antibiotics for rhinoplasty, he or she **should not** routinely prescribe antibiotic therapy for a duration of more than 24 hours after surgery.

Nasal packing

Surgeons **should not** routinely place packing in the nasal cavity of rhinoplasty (with or without septoplasty) patients at the conclusion of surgery.

The panel group made the following statement an *option*:

Perioperative steroids

The surgeon, or the surgeon's designee, may administer perioperative systemic steroids to the rhinoplasty patient.

Guideline authors

Lisa E. Ishii, MD, MHS; Travis T. Tollefson, MD, MPH; Gregory J. Basura, MD, PhD; Richard M. Rosenfeld, MD, MPH; Peter J. Abramson, MD; Scott R. Chaiet, MD, MBA; Kara S. Davis, MD; Karl Doghramji, MD; Edward H. Farrior, MD; Sandra A. Finestone, PsyD; Stacey L. Ishman, MD, MPH; Robert X. Murphy, Jr., MD, MS, CPE; John G. Park, MD, FCCP, FAASM; Michael Setzen, MD; Deborah J. Strike, BSN, CORLN; Sandra A. Walsh, BS (MdT); Jeremy P. Warner, MD; and Lorraine C. Nnacheta, MPH.

AAO-HNSF Guideline development process and the obligations associated with the guideline recommendations are documented in the *Clinical Practice Guideline Development Manual, Third Edition: a quality-driven approach for translating evidence into action*. (**http://oto.sagepub.com/content/148/1_suppl/S1.long**)

Disclaimer

The clinical practice guideline is not intended as the sole source of guidance in managing candidates for rhinoplasty. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. The guideline is not intended to replace clinical judgement or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosing and managing this program of care. As medical knowledge expands and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions but are not absolute. Guidelines are not mandates. These do not and should not purport to be a legal standard of care. The responsible physician, in light of all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNSF emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care, or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results. ■

New resources for patient information

The AAO-HNSF is providing Members with access to downloadable patient health information on the guideline for improving nasal form and function after rhinoplasty, including instructions on how to customize the handouts with your office or institutional logo at http:// www.entnet.org/rhinoplastyCPG.

Spread the love

Share the message

Kids ENT Health Month

Visit **www.entnet.org/KidsENT** to Download Patient Resources

Managing cerumen in children

By **Dale A. Tylor, MD, MPH**, Chair of the AAO-HNS Media and Public Relations Committee

Infants and children have frequent contact with their primary care physicians, both for regular well-child visits and for times of sickness. Otoscopic examination is typically performed at most visits, and cerumen is commonly identified, with studies citing a 10 percent prevalence of cerumen in the pediatric population and up to three-fold that amount in individuals with significant cognitive disabilities. Cerumen in children can be asymptomatic, or it can be associated with symptoms of otalgia, pruritus, aural fullness, hearing loss, otorrhea, or foul odor. It can block visualization of the tympanic membrane, which has implications in elucidating the etiology of fever, speech delay, or otalgia.

Children with developmental delays or autism spectrum form a special subgroup that can be more at risk of placing their fingers or foreign bodies in the ears in response to otalgia from otogenic sources, such as otitis media or otitis externa, or referred sources including teething or pharyngitis. This can increase the risk of cerumen impactions. Children who require hearing aids or FM systems in their educational environments can also be at elevated risk of such impactions.

Even single-sided hearing deficiency from cerumen impaction can have significant impacts on language and academic performance and should not be discounted.

The Academy's updated clinical practice guideline for cerumen impaction, found at http://www.entnet.org/cerumenCPG, is meant to aid all clinicians who diagnose and manage cerumen impactions. While these guidelines are not specific to children, there are some important points to understand in this special population.

- Familial practices strongly influence the habit of cleaning one's ears, and as such, **family members must be included in education** about primary prevention efforts against cerumen impactions with proper ear hygiene. Using cotton tip swabs or other objects in the ear should be discouraged.

- **Cerumen can significantly hinder visualization of the tympanic membrane or the ability to perform pneumatic otoscopy,** which are critical components in the diagnosis of the common childhood problems of acute otitis media or chronic otitis media with effusion.

Factors that can modify the management of cerumen in children include the presence of tympanostomy tubes or tympanic membrane perforations, immune compromise, or diabetes, ear canal stenosis, the use of hearing aids, or active otitis externa.

- **Children may be unable or unwilling to report hearing loss or other otologic**

complaints, and clinical suspicion for such issues must remain high, especially in situations of language or motor delays.

- **Symptomatic cerumen should be removed by a clinician capable of treating pediatric patients,** as should cerumen blocking the view of the tympanic membrane and middle ear in a child with suspected middle ear disease.

- In a setting of an uncooperative child, it is appropriate to refer to a clinician experienced in addressing otologic disease in pediatric patients using specialized equipment in the clinic, sometimes with the help of an assistant. **In rare circumstances in which the risk of awake removal of cerumen is high, a sedated procedure may be necessary.**

- Management of cerumen can include observation, cerumenolytic agents, irrigation, or manual removal with instrumentation. Cerumenolytic agents are not recommended before age three or when tympanic membrane is not intact.

- **Ear candling or ear coning are not recommended,** as they are not effective modalities to clear cerumen and can cause serious injuries including burns to the ear canal, damage to the tympanic membrane, conductive hearing loss, ear blockage, otitis externa, or fire.

- Outcomes should be assessed at the end of the in-office treatment of cerumen impaction with documentation of the resolution of the impaction. If the impaction cannot be completely cleared, the patient should be referred to a specialist. If symptoms of obstruction persist despite clearing the impaction, the clinician should evaluate the patient for an alternative diagnosis.

- Education of families about secondary prevention efforts against cerumen re-accumulation is useful when a child is prone to develop a cerumen impaction. ■

Academy updates **CPT for ENT** articles

As part of a process to continue to provide the most up-to-date resources for our membership, Academy Current Procedural Terminology (CPT) experts have begun to re-evaluate and update the Academy's list of CPT for ENT articles.

CPT for ENT articles are a collaborative effort among the Academy's team of CPT advisors, members of the Physician Payment Policy (3P) Workgroup, and health policy staff. Articles are developed to address common coding questions received by this health policy team as well as to clarify coding changes and correct coding principles for frequently reported otolaryngology-head and neck surgery procedures. These updated articles help the Academy to provide Members with the latest coding resources.

The recently updated CPT for ENT articles are "Saccadic Testing during ENG" and "Eagle's Syndrome."

All updated CPT for ENT articles can be found at **www.entnet.org/content/cpt-ents** as part of the Academy's Coding Corner.

In addition to CPT for ENT articles, the Academy's Coding Corner offers access to relevant American Medical Association (AMA) CPT Assistant articles, annual code change summaries, template appeal letters, ICD-10 coding resources, and information on Centers for Medicare & Medicaid Services (CMS) quality initiatives and reporting programs.

All of these resources can be found at the Academy's Coding Corner (**www.entnet.org/content/coding-corner**).

Important Disclaimer Notice ***(Updated Aug. 7, 2014)***
CPT for ENT articles are a collaborative effort between the Academy's team of CPT Advisors, members of the Physician Payment Policy (3P) workgroup, and health policy staff. Articles are developed to address common coding questions received by the health policy team, as well as to clarify coding changes and correct coding principles for frequently reported ENT procedures. These articles are not intended as legal, medical, or business advice and are not a guarantee of reimbursement. The information is also not meant to serve as the definitive or sole authority on billing and coding issues. The applicability of AAO-HNS billing and coding guidance for a particular procedure, must be determined by the responsible physician in light of all the circumstances presented by the individual patient. You should consult with your own advisors as well as Medicare or private carriers in making any decisions about how to bill and code particular services or procedures.

CPT for ENT: Electro-oculography

Q: Can otolaryngologists report the CPT code 92270 (electro-oculography with interpretation and report) to indicate saccadic testing during an electronystagmography/videonystagmography (ENG/VNG) procedure?

A:

No. It has come to the Academy's attention that otolaryngologists are reporting CPT code 92270 Electro-oculography with interpretation and report to describe saccadic testing during an ENG or VNG procedure. To follow the American Medical Association's Current Procedural Terminology (CPT®) guidelines, providers should only use this code to document a standard test of the electrical potential created in a retina when exposed to light for the diagnosing of best vitelliform maculopathy.

As a result, otolaryngologists and their practices should not report CPT code 92270 with ENG/VNG testing (CPT codes 92541-92547, Vestibular Functions Tests, With Recording).

To ensure optimal reimbursement for any services rendered, remember to submit detailed clinical documentation that supports the physician's treatment rationale. ■

Approved June 2008
Revised November 2016

CPT for ENT: Eagle's Syndrome

Q: How do I code for Eagle's Syndrome and its treatment?

A: Eagle's Syndrome is a condition caused by an elongated styloid process or calcified stylohyoid ligament. Symptoms may include dull pain of the throat, neck and face, dysphagia, and foreign body sensation of the throat. Treatment of this syndrome is usually done by surgically shortening the styloid process (typically transorally) and/or addressing the calcified ligament, if needed, (typically with a cervical approach).

As there is no specific ICD-9 code for the syndrome, it is best to code for symptoms presented by the patient. They are typically facial pain (784.0), throat pain (784.1), neck pain (723.1), and dysphasia (784.5). Other options may include other disorders of muscle, ligament, and fascia (728.89).

Suggested crosswalk to ICD-10 codes:

784.0 ⟶ G50.1 (atypical facial pain)

784.1 ⟶ R07.0 (pain in throat)

723.1 ⟶ M54.2 (cervicalgia)

784.5 ⟶ R13.19 (other dysphagia)

728.89 ⟶ M62.89 (other specified disorders of muscle)

Another potential option is M89.8X8 (other specific disorders of bone, unspecified site). When coding for shortening of the styloid process use CPT code 21499 Unlisted musculoskeletal procedure, head. Make sure your operative note clearly details the procedure performed. ■

Reviewed 8/4/06
Revised November 2016

Hypoglossal nerve stimulator

New Category III codes

New Category III codes have been established in the Current Procedural Terminology (CPT®) 2017 code set to report implantation of a hypoglossal nerve stimulation system that includes the placement of a chest wall sensor. Previously, this entire service was reported with code 64999, Unlisted procedure, nervous system (see CPT Assistant September 2011). This article provides an overview of these changes.

New Category III codes

The new codes describe the implantation, revision, replacement, or removal of the chest wall sensor(s) attached to a cranial nerve neurostimulator electrode array and pulse generator for the treatment of selected patients with obstructive sleep apnea. Note that these new codes will be effective for use on January 1, 2017, and they are available on the CPT Category III website at **https://www.ama-assn.org/practice-management/cpt-category-iii-codes.**

Publication of the Category III codes to the CPT website takes place on a semiannual basis when the codes have been approved by the CPT Editorial Panel. The full set of temporary Category III codes for emerging technology, services, procedures, and service paradigms are published annually in the code set for each CPT publication cycle. As part of the electronic distribution, there is a six-month implementation period from the initial release date (i.e., codes released on January 1 are eligible for use on July 1, and codes released on July 1 are eligible for use on January 1).

Category III code 0466T is an add-on code to report in conjunction with code 64568 for the primary placement of a hypoglossal nerve stimulator and generator that includes a chest wall sensor electrode or electrode array. If the surgeon were to insert a hypoglossal nerve stimulator that does not require or include a chest wall sensor electrode or electrode array, then only code 64568 may be reported.

+λ0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure). (Use 0466T in conjunction with 64568.)
λ0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator (Do not report 0467T in conjunction with 0466T, 0468T.) (For revision or replacement of cranial nerve [e.g., vagus nerve] neurostimulator electrode array, including connection to existing pulse generator, use 64569.)
λ0468T	Removal of chest wall respiratory sensor electrode or electrode array (Do not report 0468T in conjunction with 0466T, 0467T.) (For removal of cranial nerve [e.g., vagus nerve] neurostimulator electrode array and pulse generator, use 64570.)

Codes 0467T and 0468T, which are not add-on codes, may be reported for either the revision and replacement or removal of the chest wall sensor electrode or electrode array, respectively. If the hypoglossal nerve stimulator array and generator were also revised, replaced, or removed, existing codes 64569 or 64570 may be reported. ■

CPT changes for 2017: what

There are several Current Procedural Terminology® (CPT) code changes for 2017 applicable to otolaryngologist-head and neck surgeons. Below is a summary of these changes. If you have any questions regarding CPT code changes for 2017, please contact the Health Policy team.

What ENTs need to know

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 (CPT) 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 (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 2017. The following outlines a list of codes changed in 2017, including new and revised CPT codes, as well as codes which were reviewed by the AMA RUC in 2017 and could have modified Medicare reimbursement values:

New or modified codes

In CY 2017, changes were made to the following CPT codes and were valued by the AMA RUC:

- **+ 0466T**-Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator
- **0467T**-Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator
- **0468T**-Removal of chest wall respiratory sensor electrode or electrode array
- **31580**-Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion
- **31584**-Laryngoplasty; with open reduction and fixation (e.g., plating) of fracture, includes tracheostomy, if performed
- **31587**-Laryngoplasty, cricoid split, without graft placement
- **31591**-Laryngoplasty, medialization; unilateral
- **31592**-Cricotracheal resection
- **92612**-Flexible endoscopic evaluation of swallowing by cine or video recording
- **92613**-Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation and report only
- **92614**-Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording
- **92615**-Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only
- **92616**-Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording
- **92617**-Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; interpretation and report only
- **95144**-Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
- **95165**-Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

(A November 2016 *CPT Assistant* article provides clarification on the use of **0466T-0468T**.)

In the CY 2017 Medicare Physician Final Rule, CMS published values for the Laryngoplasty and Laryngoscopy codes that the Academy disagreed with. In comments to CMS for the final rule, the Academy presented additional information in hopes of CMS publishing a more appropriate value for these codes in CY 2018.

Codes reviewed by the AMA RUC in CY 2016

In addition to the creation of several new CPT codes for 2017, 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 2018 final rule. Members should be prepared for modified relative value units for some, or all, of these procedures in CY 2018. CMS will publish 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 Member's behalf. Final values 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 which were reviewed include:

- **30901**-Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

ENTs need to know

- **30903**-Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
- **30905**-Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
- **30906**-Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent
- **31551**-Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age
- **31552**-Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older
- **31553**-Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age
- **31554**-Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older
- **31572**-Laryngoscopy, flexible; with ablation or destruction of lesion(s) with fiber based laser, unilateral
- **31573**-Laryngoscopy, flexible; with therapeutic injection(s) (e.g., chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
- **31574**-Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral
- **31575**-Laryngoscopy, flexible; diagnostic
- **31576**-Laryngoscopy, flexible; with biopsy
- **31577**-Laryngoscopy, flexible; with removal of foreign body(s)
- **31578**-Laryngoscopy, flexible; with removal of foreign lesion(s), non-laser
- **31579**-Laryngoscopy, flexible or rigid telescopic, with stroboscopy
- **31600**-Tracheostomy, planned (separate procedure)
- **31601**-Tracheostomy, planned (separate procedure); younger than two years
- **31603**-Tracheostomy, emergency procedure; transtracheal
- **31605**-Tracheostomy, emergency procedure; cricothyroid membrane
- **31610**-Tracheostomy, fenestration procedure with skin flaps
- **30140**-Resection of turbinate ■

ENT TOP 100 CPT 2017 CODES

Top 100 ENT services for 2017

The Academy has prepared resources outlining the 100 most frequently reported Current Procedural Terminology (CPT) codes by providers with subspecialty designation "4-Otolaryngology" within the Medicare enrollment database. In order to continue to provide the most up-to-date resources for our membership, two updated charts are now available for the 2017 Top 100 ENT Codes Billed in a Physician Office and the 2017 Top 100 ENT Codes Billed in the Hospital Outpatient Department.

The 2017 Top 100 ENT Codes Billed in a Physician Office chart 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 2017 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 2015 Medicare claims data. Further information and the chart files can be located at **http://www.entnet.org/content/top-100-ent-cpt-codes-2017** as part of the Academy's Coding Corner.

The Academy's Coding Corner offers access to Academy coding resources. These resources include CPT for ENT articles, annual code change summaries, and ICD-10 coding resources. All of these resources can be found at the Academy's Coding Corner **(www.entnet.org/content/coding-corner).** ■

AAO-HNS Member Call to Action

Stop the Bleed® provides resources to educate the public on how to recognize life-threatening bleeding, on what to do in situations if there is a bleeding control kit available, and what to do if there is not a bleeding control kit available. The campaign details how to properly apply a tourniquet, how to pack a wound, and how to apply pressure using a clean cloth.

Provide essential resources in your community to promote the Stop the Bleed® campaign

SEE SOMETHING. DO SOMETHING. IMPROVE SURVIVAL.

Join the Stop the Bleed® initiative and the bleeding control initiative from the American College of Surgeons (ACS), the ACS Committee on Trauma, and the Hartford Consensus. This is a nationwide campaign empowering individuals to act quickly and save lives—much like the successful CPR education campaigns that began decades ago.

Uncontrolled bleeding injuries can result from natural and manmade disasters, everyday accidents, and an active shooter or intentional mass casualty event. A victim suffering from severe bleeding often needs quicker assistance than the arrival of first-responders for medical care. The Stop the Bleed campaign highlights how civilian bystanders, if trained, can act as immediate responders to keep the injured person alive until appropriate medical care is available.

To determine the public's willingness to this endeavor, the Hartford Consensus conducted a national survey[1] regarding bleeding control. The survey found that there is a high level of interest to act to help stop bleeding. The level of willingness of survey respondents increased if they were offered training in bleeding control as well as the availability of bleeding control kits in public places.

The survey found more than 90 percent of respondents indicated they would be likely to help someone they didn't know who was bleeding. Regarding interest in being trained, 82 percent of those physically able to provide aid indicated they would be very interested or somewhat interested in attending a local two-hour class on bleeding control and other first aid techniques.

CALL TO ACTION: The Academy supports the success of this initiative to increase the number of civilian first responders trained and able to render assistance to victims of mass shootings and other mass casualty situations, or any cause resulting in uncontrolled bleeding. As a society of medical professionals, our Members can join and extend the efforts of this nationwide campaign by offering to provide these valuable resources to schools, civic groups, churches, etc.

To date, the Academy has provided the training to the AAO-HNSF staff, shared materials with the nursing programs and hospitals, and plans to conduct training at the AAO-HNS/F 2017 Leadership Forum and BOG Spring Meeting in March.

All resources are available at **http://www.bleedingcontrol.org/resources** and ready to download. This includes diagrams, news articles, videos, and other resources to educate the public on proper bleeding control techniques. In the next few months, available classes will be listed on the website. Join the conversation on Twitter **@bleedingcontrol.** ■

"Stop the Bleed" is a registered service mark of the Department of the Defense.

Reference

1. The Hartford Consensus: A National Survey of the Public Regarding Bleeding Control: J Am Coll Surg. 2016. http://www.journalacs.org/article/S1072-7515(16)00168-X/fulltext

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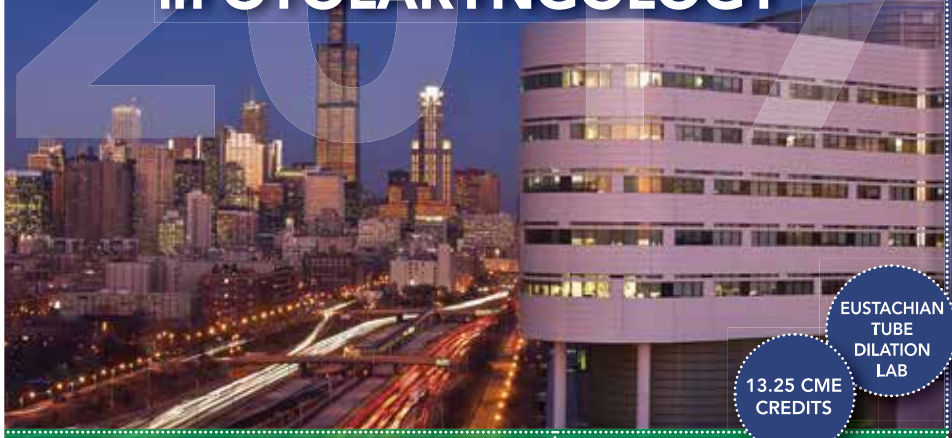

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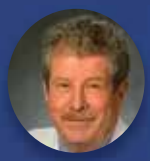

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Edward Wood, MD
Director, Pediatric Otolaryngology
wewood@geisinger.edu

cc: Sarah Lipka
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Stanford University School of Medicine
Department of Otolaryngology-Head and Neck Surgery

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or email to: jkeys@uthsc.edu

The University of Tennessee is an EEO/AA/Title VI/Title IX/ Section 504/ADA/ADEA/V institution in the provision of its education and employment programs and services.

A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology

HEAD AND NECK SURGEON

- VA Otolaryngology Division Chief
- Part-time appointment at Medical College of Georgia at Augusta University
- Rank commensurate with experience
- Excellent resources are available
- Fellowship training required
- Interest in reconstruction preferred

To apply and receive additional information, please contact:

Stil Kountakis, MD, PhD, Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
1120 Fifteenth Street, BP-4109, Augusta, Georgia 30912-4060
Phone: 706-721-6100
Email: skountakis@augusta.edu

AUGUSTA UNIVERSITY

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

University of Maryland - Baltimore

Otorhinolaryngology - HNS

The Department of Otorhinolaryngology – Head and Neck Surgery is seeking a board certified or board eligible, full-time, academic Rhinologist/Anterior Skull Base Surgeon to join the faculty. The candidate should have fellowship training in the subspecialty. The candidate will have an appointment at the University of Maryland School of Medicine. Responsibilities will include teaching of medical students and residents, patient care and research.

Faculty rank, tenure status and salary will be commensurate with the level of experience. Qualified applicants should submit their Curriculum Vitae and the names of three references to:

Rodney J. Taylor, MD, MSPH, FACS
Director of Division of General Otolaryngology –
Head & Neck Surgery
Department of Otorhinolaryngology – Head & Neck Surgery
University of Maryland
16 South Eutaw St., Suite 500
Baltimore, MD 21201-1619

The University of Maryland, Baltimore is an Equal Opportunity, Affirmative Action employer. Minorities, women, individuals with disabilities, and protected veterans are encouraged to apply.

MetroHealth

Academic Otology Position

MetroHealth Medical Center is seeking a Board certified, fellowship-trained Otologist or general Otolaryngologist with significant experience in Otology interested in an adult and pediatric Otology practice including chronic ear disease, hearing disorders, vertigo, and balance disorders to join our active and growing Department.

The position is based at MetroHealth Medical Center and provides the opportunity to take over and expand a well-established practice at Metro's main campus Metro's satellite offices. In addition to a busy clinical practice, the position offers teaching and research opportunities.

MetroHealth is an affiliate of the Case Western Reserve University School of Medicine and trains Otolaryngology – Head & Neck Surgery residents and CWRU medical students.

MetroHealth Medical System is an integrated health system with an acute-care hospital housing a Level I Adult Trauma and Burn Center, a skilled nursing facility, and more than 25 locations throughout Cuyahoga County. Annually, there are more than one million patient visits to the system, including more than 100,000 in the Emergency Department, one of the busiest in the country.

The position is available immediately.
Interested applicants should send a current CV to:

David W Stepnick, MD, FACS
Interim Chair, Department of Otolaryngology - Head & Neck Surgery
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, Ohio 44109

MetroHealth is an equal opportunity/affirmative action employer. Women and minorities are encouraged to apply.

HARVARD MEDICAL SCHOOL | Massachusetts Eye and Ear | MASSACHUSETTS GENERAL HOSPITAL

General Otolaryngology

The Department of Otolaryngology at Massachusetts Eye and Ear/Harvard Medical School seeks a qualified candidate for a full-time position at its South Suburban Center, a practice with 10-physicans at 5 office locations. The successful candidate would have the opportunity for a broad clinical practice in General Otolaryngology. In addition, there are opportunities to participate in basic and clinical research and/or teaching within Massachusetts Eye and Ear and Harvard Medical School. The successful candidate must be Board certified or Board eligible in Otolaryngology.

Please send letter of interest and curriculum vitae to:

Peter N. Friedensohn, MD
Medical Director
Massachusetts Eye and Ear
South Suburban Center
Quincy, Massachusetts 02169
617-774-1717
Peter_Friedensohn@meei.harvard.edu

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

SOUTHERN CALIFORNIA COASTAL ENT PRACTICE

Well established otolaryngology practice covering all sub-specialties is searching for an enthusiastic and energetic otolaryngologist who would like to practice in a highly sought after Southern California coastal community.

Other highlights include…

- Very light call
- High income potential
- Fully equipped otolaryngology offices including audiology, allergy, CT Scanner
- Fully certified surgical center/OR
- Friendly, efficient staff and attractive offices

This is an excellent opportunity for a Board Certified or Board Eligible Otolaryngologist. Initially employed contract with potential for partnership track. Relocation package.

This location is between Los Angeles and Santa Barbara. With the Channel Islands in the distance, it provides a great family and recreational environment.

For more details please contact us at:
coastalENTopportunty@gmail.com

Chester County Otolaryngology & Allergy Associates

SCENIC PHILADELPHIA SUBURBS

- Flourishing four physician Otolaryngology practice seeking an additional BC/BE physician.
- Located in beautiful Chester County, Pennsylvania's fastest growing county, with easy access to Philadelphia, New York City, Washington DC, mountains, and shoreline.
- Current services include audiology with hearing aid dispensing and balance testing, sinus surgery and allergy testing/immunotherapy, endocrine surgery, head and neck oncologic surgery, reconstruction of malignant cutaneous defects, and general pediatric and adult otolaryngology.
- 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 ccofps@comcast.net.

The Ear, Nose, Throat & Plastic Surgery Associates

- General Otolaryngologist
- Neurotologist
- Head and Neck Surgeon

The largest otolaryngology group in Central Florida, which offers a full array of subspecialty care including emphasis in general otolaryngology, neurotology and head and neck surgery, is seeking several partners. We offer the best of private practice with opportunities for academic pursuits. Integrity, quality and camaraderie are our core values.

We offer an excellent salary, benefits, partnership and the opportunity to teach residents and medical students, if desired. Orlando is a world destination offering a variety of large city amenities and is a short drive to both the East and West Coasts of sunny Florida.

For more information, visit us online at www.entorlando.com

Interested candidates should send CV to or may contact:
Debbie Byron, Practice Administrator
Phone: Cellular: 407-342-2033
E-Mail: dbyron@entorlando.com

Washington University in St. Louis
SCHOOL OF MEDICINE

CHIEF, HEAD & NECK SURGERY

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine invites applications for a full-time faculty position at the Associate Professor/Professor level in the Division of Head & Neck Surgery. We are seeking candidates with the vision and leadership abilities to serve the role of Division Chief, Head & Neck Surgery within the Department and to lead the institutions multidisciplinary cancer care effort in this discipline. This position includes an Endowed Chair and substantial support for building the basic and translational research efforts in head & neck cancer as a part of the extraordinary research environment at Washington University School of Medicine. Fellowship training or extensive experience in head & neck oncologic surgery and multidisciplinary cancer care is required. We encourage candidates with a strong research background and a commitment to education to apply. This position will include patient care responsibilities at Barnes-Jewish Hospital & the Siteman Cancer Center, an NCI Comprehensive Cancer Center & member of the National Comprehensive Cancer Network (NCCN). Candidates must be able to obtain a Missouri State license and must be board certified or eligible for certification. Interested applicants are invited to submit their CV on the WUSM website at: https://facultyopportunities.wustl.edu

Craig A. Buchman, MD, FACS
Lindburg Professor and Head
Department of Otolaryngology-Head & Neck Surgery
Washington University School of Medicine

Washington University in St. Louis is committed to the principles and practices of equal employment opportunity and affirmative action. It is the university's policy to recruit, hire, train, and promote persons in all job titles without regard to race, color, age, religion, gender, sexual orientation, gender identity or expression, national origin, veteran status, disability, or genetic information.

BARNES-JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians | Children's Hospital St. Louis

NORTHERN ARIZONA EAR NOSE & THROAT PC

We are recruiting a second FT general/surgical otolaryngologist (BC/BE) for our highly successful ENT practice (one physician owner/founder) located in Flagstaff, Arizona.

Our practice is well established and expanding to better serve Flagstaff and surrounding communities.

Practice Highlights

- **Busy, ready-made practice with a strong referral base**
- **Work out of one hospital and one satellite clinic in Sedona, AZ**
- **Dedicated suite in our ASC**
- **Audiology on site**
- **1:5 call schedule for hospital (may change)**
- **EMR (Athena)**
- **Completive Salary and Benefits**
- **Flexible to offer tailored hours for balance of work and lifestyle**
- **Cohesive office staff dedicated to providing the best medical care**

Nestled at the base of the San Francisco Peaks, Flagstaff has the charm of a small town with the diversity and opportunities of a big city. It is a recreation destination for all seasons. The home of Northern Arizona University, Flagstaff is the hub of many of the state's natural attractions, including the Grand Canyon, Lake Powell, Snowbowl Ski Resort and Sedona, with an easy two hour drive to Phoenix.

Interested applicants should send a current CV to:

Northern Arizona Ear, Nose & Throat, PC
1300 Rim Drive, Suite B, Flagstaff, AZ 86001
928-606-2150
Fax: 928-556-0336 • flagstaffdowns@gmail.com • NAENT.COM

Children's National

Children's National Health System is seeking a qualified candidate for a non-tenured faculty position at the Assistant Professor level, the George Washington Univeristy Medical school, to function as a full time member in the Division of Otolaryngology. The position is effective July 2017.

Requirements for the position are candidates with an MD or equivalent degree, Board Certified or Board Eligible in Otolaryngology, and Fellowship trained in Pediatric Otolaryngology.

Responsibilities for the position include full time clinical and surgical care of patients, research to advance knowledge and understanding of pediatric otolaryngology, and education of medical students, residents and fellows.

Children's National Health System is an affirmative action and equal opportunity employer. We do not discriminate based on race, color, sex, religion, national origin, age, disability, marital status, ancestry, personal appearance, sexual orientation, family responsibility, matriculation, political, or any other unlawful basis. Interested candidates should send their curriculum vitae and letter of interest to:

Eric N. Baker, M.H.S.A.
Program Manager, Otolaryngology
Children's National Health System
111 Michigan Avenue, N.W.
Washington, D.C. 20010
202-476-8389

For complete details on this position and to apply online, please visit careers at: www.childrensnational.org and search by Requisition #160000FD

Pediatric Otolaryngology Faculty Positions

The Indiana University School of Medicine (IUSM) Department of Otolaryngology-Head & Neck Surgery in Indianapolis, Indiana is seeking full time BC/BE faculty physicians to join its comprehensive and growing department. Responsibilities include participation in an active pediatric otolaryngology practice, teaching residents and medical students, and participating in scholarly activities. Candidates must be fellowship-trained in all aspects of pediatric otolaryngology. Rank and salary will be commensurate with level of experience.

Riley Hospital for Children at IU Health

Riley Hospital for Children is a tertiary care teaching hospital located in downtown Indianapolis serving more than 300,000 children per year. Our practice includes the spectrum of pediatric otolaryngology including complex airway and sleep, head & neck masses/congenital malformations, hearing loss/otology, craniofacial, rhinology, laryngology/pediatric voice, speech, and vascular anomalies.

Riley Hospital for Children at IU Health North Hospital

IU Health North is a full service 189-bed hospital located 10 miles north of downtown Indianapolis. This state-of-the-art facility has dedicated pavilions for specialty surgery and an attached medical office building. Our practice focuses on general pediatric otolaryngology, including sleep disorders, airway disorders, rhinology and otology.

Please indicate position of interest, submit CV and arrange to have three letters of reference sent to:

Marion Everett Couch, MD PhD MBA FACS
Richard T. Miyamoto Professor and Chair
Department of Otolaryngology – Head & Neck Surgery
Indiana University School of Medicine

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Fesler Hall • 1130 W. Michigan St, Suite 400 • Indianapolis, IN 46202 • smaxwell@iupui.edu

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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 recently launched the Robotics Institute and added a Vascular Malformations Program. Additionally, our experts are on the faculty of the Icahn School of Medicine at Mount Sinai, ranked among the nation's top medical schools by *U.S. News & World Report*, and the Head and Neck Cancer Research Program is the foremost international resource for tumor dormancy research.

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

Mount Sinai *New York*

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