

bulletin

American Academy of Otolaryngology—Head and Neck Surgery

May 2014—Vol.33 No.05

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Abbreviations ... You Need to Know

**Health Policy 101:
Working for You**

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bulletin

American Academy of Otolaryngology—Head and Neck Surgery

May 2014—Vol.33 No.05



Health Policy 101: Working for You

18



AMERICAN ACADEMY OF
OTOLARYNGOLOGY—
HEAD AND NECK SURGERY

David R. Nielsen, MD
Executive Vice President, CEO, and Editor,
the *Bulletin*

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We Have You Covered

This issue features the work of our volunteer members in concert with AAO-HNS Health Policy staff on topics that you want to know about. This coverage begins with my thoughts and the Feature Section and Legislative Advocacy Sections deliver more relevant information.

Also, this May *Bulletin* coincides with the opening of registration for the AAO-HNSF 2014 Annual Meeting & OTO EXPOSM. An exciting look at what it will offer can be found in the Preliminary Program that is in your mailing along with **David R. Nielsen, MD's** pertinent observations on page 7 and a special section every month to highlight aspects of the much anticipated event that impacts your everyday practice.

Changes Ahead

There has never been another time in my professional career when so much change has occurred in the field of healthcare in such a short time. I know AAO-HNS members, who are working diligently on behalf of their patients, feel this—whether you're in a small, rural community practice or in an urban academic setting. Meaningful Use, Quality reporting within the Medicare program, ICD-10, and the Affordable Care Act (ACA) have created resource intensive, overlapping regulatory changes that are affecting, and will for years, the way physicians do business. Positive outcomes depend on physicians' readiness and willingness to adapt to these changes. More changes are likely as the AAO-HNS Membership and

staff continues to work with other specialty societies and Hill leaders to permanently repeal the Sustainable Growth Rate (SGR) formula and develop longer lasting payment reform for a new Medicare payment system to incentivize the delivery of high-quality, efficient healthcare.

The Health Policy staff, working with the Academy's Physician Payment Policy (3P) workgroup, co-chaired by **James C. Denny III, MD**, and **Jane T. Dillon, MD, MBA**, provides valuable services to members that *empower otolaryngologist-head and neck surgeons to deliver the best patient care*. Through services such as these listed, we work for you!

- 2014 Annual Meeting educational seminars transitioning to ICD-10 and alternative payment models,
- Tools like the ICD-10 Superbill and CMS Quality Fact Sheets,
- Advocacy to the AMA and CMS on CPT, the RUC, and reimbursement issues;
- Advocacy to the CMS and private insurance companies for fair and appropriate valuation, payment, and coverage of otolaryngology-head and neck services,
- Payer template appeal letters,
- CPT for ENT coding guidance articles,
- Position Statements and Clinical Indicators,
- Summaries of annual rule making and policy changes,
- Communications on annual ENT coding and reimbursement rate changes,



Richard W. Waguespack, MD
AAO-HNS/F President

- Maintain the New Technology Pathway to help integrate innovations into coding and reimbursement.

3P and the Health Policy team recognize that physicians today are facing numerous changes in coding and reporting requirements. Adherence and non-adherence to deadlines and requirements can significantly affect physicians' practices. **The value that 3P and the Health Policy team offer to members includes a single source for preparing for the changes, and peace of mind that despite these challenging times, AAO-HNS helps physician members continue to provide excellent patient care.**

Socioeconomic Survey

3P and Health Policy strive to do what is best for you and your patients. They continually need your feedback from all members and specialty societies as they interact with payers and regulatory entities.

The 2014 AAO-HNS/F Socioeconomic Survey captured trend data from more than 1,000 members, reflecting the ever-changing healthcare environment and providing insight on the future of the specialty. The results of the survey will be on display at the AAO-HNSF 2014 Annual Meeting & OTO EXPOSM in Orlando, Florida, where I look forward to seeing you all and welcome the next AAO-HNS/F president. **5**

3P Workgroups

Chairs

- James C. Denny III, MD, Coordinator for Socioeconomic Affairs
- Jane T. Dillon, MD, MBA, Coordinator for Practice Affairs (also Alternate RUC Panel Member)
- Michael Setzen, MD, Immediate-Past Coordinator for Practice Affairs

RUC Team

- Wayne M. Koch, MD, AAO-HNS RUC Advisor

- John Lanza, MD, AAO-HNS RUC Advisor Alternate

- Jane Dillon, MD, AAO-HNS RUC Member Alternate
- Peter M. Manes, MD, AAO-HNS RUC Trainee
- Charles F. Koopmann, Jr., MD, MHSA, RUC Panel Member, CPT Assistant Editorial Board Member

- Bill Moran, MD, Immediate-Past RUC Practice Expense (PE) Subcommittee Chair

CPT Team

- Bradley F. Marple, MD, AAO-HNS CPT Advisor

- Lawrence M. Simon, MD, AAO-HNS CPT Advisor Alternate
- Richard W. Waguespack, MD, Advisor for Triological Society, Immediate-Past Coordinator for Socioeconomic Affairs
- Lee Eisenberg, MD, Past CPT Panel Member and CPT Representative to RUC, Past Government Relations Coordinator

Quality Expert

- Emily Boss, MD, MPH

Payment Models Expert

- Robert Lorenz, MD, MBA



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The Lessons of Lifelong Learning

This month, you will find the traditional emphasis on the upcoming Annual Meeting & OTO EXPOSM that will take place September 21-24 in Orlando, Florida. While this annual event marks the highlight of the year for many of our members, and is rated one of the highest and most valued products or services the Academy provides to otolaryngologists from around the world, I'd like to add another perspective about the value of our exceptional meeting and the lifelong learning process to which it contributes. None of us practices medicine in exactly the same way we were taught during our residencies. While many foundational principles, values, and ethics are timeless and will never change, advances in understanding, new basic science, technological accelerators, and clinical approaches have positively altered what we thought we knew when we entered practice. Sometimes the new knowledge or clinical change occurs almost before the ink is dry on the publication of the previous knowledge.

I came across one such example a few weeks ago as I participated in a unique and energizing conference at the Massachusetts Institute of Technology in Boston. The event was a "hackathon" designed to gather volunteer scientists, students, patients, health plans, teachers, and anyone else interested in improving healthcare into one room to express their "pain point" or perspective on what needed to improve and how we could think about changing it. Participants were granted 60 seconds to describe their "pain point." After hearing from dozens of participants, tracks or themes began to congregate around possible common ideas. By the early afternoon on the first day, teams were beginning to form and discuss solutions and approaches. By the end of the day, specific proposals of defined groups started to formalize their proposals. On the second day, mentors from industry, academia, and public interest groups met with each team to assist them in the design, business modeling, and presentation of their proposals. Several hours of three-minute proposals were then

heard in each track; judges questioned the presenters; and awards were given sponsored by those stakeholders who offered resources to bring these ideas to fruition.

It was exhilarating to say the least!

Winning awards included proposals to:

- Build shoes with tiny lights shining a point 12 inches in front of each step to encourage Parkinsonian patients to improve their gait.
- Create low cost lighting systems available to poverty-stricken areas of the world to treat jaundiced newborns.
- Create a database of 68 points from facial recognition software donated by the developer to diagnose rare genetic disorders afflicting 350 million people globally (ironic that 7,000 "rare disorders" collectively are not really rare at all, but afflict nearly 10 percent of the U.S. population!).

In each instance, the proposals offered benefits to millions of patients, and the business models for start-up or proof of concept were only a few thousand dollars. Talk about a return on investment! Each presentation included published, accurate, statistically sound, documentation of need, proof of concept and relative benefit.


As I thought of our own research and education programming, I considered how this approach was markedly different from how I was taught and how many clinician scientists still approach translational research today. For example, the explosion of genetic knowledge in the last decade overturns the notion (that most of us still believe) that our genes are "fixed" and make us what we are—even though we now have extensive evidence of how our experiences, exposures, diet, and even our behavior and attitudes can change our genetic makeup and what we pass on to successive generations. The study of epigenetics has dramatically affected what we previously thought we knew about genetics. I highly recommend a new book entitled *Inheritance: How Our Genes Change Our Lives—and How Our Lives Change Our Genes*, by Sharon Moalem. He is an MD/PhD geneticist and



David R. Nielsen MD

David R. Nielsen, MD
AAO-HNS/F EVP/CEO

a best-selling author of a couple of other books, including *Survival of the Sickest: The Surprising Connections Between Disease and Longevity*. *Inheritance* is a fascinating read for any clinician, and especially for otolaryngologists as we deal with the facial, head, and neck manifestations of so many common and rare diseases. Dr. Moalem also just happens to be the developer of the facial recognition software—which he donated free to the Global Genes Project, a patient advocacy non-profit whose work it is to assist those with rare diseases to find their diagnoses and get appropriate care.

So, what's the point? Lifelong learning is essential. Basic foundations such as what we know about how our DNA affects our health are changing rapidly. We cannot afford NOT to attend the Annual Meeting & OTO EXPOSM, participate heavily in continuing education, and broaden our scientific knowledge. Simply engaging in education as a "check-off" for our CME, licensing, or MOC is not enough. As physicians, our native curiosity about biology, science, and health is our defining characteristic. And the journey of learning is a fascinating and joyous one of creativity, wonder, and growth. Come to the meeting in Orlando, share what you know, question what you don't, and engage once again in the adventure of lifelong learning. See you there! 

Starting a Habit



In January (and many previous Januaries), I resolved to take better care of myself and exercise more.

My research regarding the best way to establish a habit suggested that I should:

- Start small.
- Create a list of the benefits.
- Create a strategy.
- Set up specific goals and reward myself when I meet them.
- Consult a friend and do it together to stay motivated.

As I sat at the AAO-HNS/F's Leadership Forum and Board of Governors' (BOG) meeting March 2-3, I reflected on the great education that the BOG provides and mused on the best way to help my fellow otolaryngologists establish the habit of participating in the BOG.

What Is the BOG?

The BOG was established in 1982 as a grassroots member network within the Academy. It is made up of local, state, regional, and national otolaryngology-head and neck surgery societies in the United States. And while members within this grassroots network were traditionally community otolaryngologists, it increasingly includes members from every practice setting. Moreover, the BOG functions as an advisory body for the grassroots organizations to the Board of Directors.

Leadership Forum 2014

This year's AAO-HNS/F Leadership Forum was coupled with the BOG's spring meeting. The forum was designed to educate us on topics such as clinical practice guidelines, current federal and state legislative issues, alternative payment models, and transition to ICD-10 coding. Also new this year was the availability of free CME credit during the meeting for sessions that covered contract negotiation, the pros and cons

of hospital employment, and ICD-10 implementation. As in previous years, the candidates for AAO-HNS President-elect spoke at the Candidates' Forum and there was an opportunity to ask questions of both candidates directly.

Establishing the Habit of BOG Participation

The Board of Governors is here for all of us. We need to hear from otolaryngologists from every practice setting so we can focus our energies on the issues that are affecting our patients and our practices.

Toward that end, I propose that we all...

Start Small

Involvement in the BOG may be as simple as attendance at a spring or fall meeting, answering the BOG polls distributed through your local association or assistance in tracking local legislation as a State Tracker. To become more involved, you can serve as a representative to the Legislative Affairs Committee or the Socioeconomic and Grassroots Committee, or as the governor for your local or state society. The BOG is especially recruiting people to help track legislation in the following states: Alaska, Hawaii, Idaho, Mississippi, Nevada, New Mexico, Oregon, Rhode Island, South Dakota, and Wyoming.

List the Benefits

- Being one of the first to know what is happening with legislation affecting your livelihood.
- Free CME at the spring meeting.
- Free education on the business of medicine including ICD-10, and contract negotiations.
- Free education on how to participate and comply with CMS quality improvement initiatives such as PQRS, EHR Meaningful Use, Physician Compare, and the Value Based Payment Modifier.
- Receive guidance, support, and training on how to improve your interactions



Stacey L. Ishman, MD
BOG, Member-at-Large

**Stay alert and connect: bog@ent.org*

with local and national payers to achieve optimal reimbursement for your services.


- Training that can help you advocate at the hospital, state, and federal levels.
- Direct access to hear and question the Academy presidential nominees at the spring BOG meeting.
- Networking with other otolaryngologists
- Opportunities to share successes and challenges.
- Having fun.

Create a Strategy and Set Goals

- Sign up to be a State Tracker: govtaffairs@entnet.org.
- Sign up for the ENT Advocacy Network to receive biweekly emails on healthcare legislation and politics; <http://www.entnet.org>.
- Submit a guideline topic you would like to see presented to the Guideline Development Task Force by emailing bog@entnet.org.
- Contact your local otolaryngology society to serve as a representative to the BOG.
- Just attend the fall BOG meeting—no need to have a title or agenda.

Do It with a Friend

Bring a resident, a partner, or your practice administrator. Or come alone and make a friend.

The BOG is here to serve you. Please get involved and **make Board of Governors participation a habit!** 

The Transition Continues: Rollout of Socioeconomic Resources and Clarifying the BOG SEGR Regionalization Process

James C. Denny III, MD
Coordinator for Socioeconomic Affairs
and Co-Chair Physician Payment Policy
Workgroup

David R. Edelstein, MD
Chair of Board of Governors
Socioeconomic Grassroots Committee

As noted in last October's BOG Bulletin article, the BOG Socioeconomic Grassroots (SEGR) Committee has modified its structure. As of January 1, 2014, the SEGR has begun implementing the new regionalization model. This plan divides the country into 10 regions following roughly the same lines of division as the Department of Health and Human Services (DHHS). There will be a representative from each region charged with keeping the BOG current on socioeconomic and grassroots issues affecting that area of the country. This will be done primarily through regional reports at the fall and spring BOG meetings, conference calls, and direct communication with the BOG Executive Committee. This new structure also requires that the BOG SEGR regional representatives and leaders have an ongoing dialogue with the Academy's Physician Payment Policy Workgroup (3P) leaders, whose primary focus is to address national socioeconomic issues affecting the membership.

That dialogue will be achieved in two ways. First, representatives from the BOG SEGR committee have been included as part of the 3P workgroup to help facilitate communication on socioeconomic issues that may begin in one area, but require the input of both groups. Those leaders are **Lawrence M. Simon, MD**, (who also serves as the

Academy's Alternate CPT Advisor) and **Robert J. Stachler, MD**. Second, all 3P and BOG SEGR calls will include a standing agenda item to allow for reports from the BOG SEGR leaders to the 3P workgroup or from the 3P workgroup to the BOG SEGR regional representatives.

To further this effort to streamline communication between the two groups, and to support the BOG transition to a regional representative structure for socioeconomic and grassroots issues, the Academy Health Policy team prepared a **socioeconomic e-care package**. This document is available to all BOG SEGR representatives, and members at large, to outline the wealth of practice management resources the Academy provides to members on our website. Resources include information related to common member inquiries such as requests for coding clarification related to changes to CPT codes, national reimbursement rates, payer denials, transitioning to ICD-10, and more. These materials will support the BOG SEGR representatives in responding to members' local and state inquiries, as

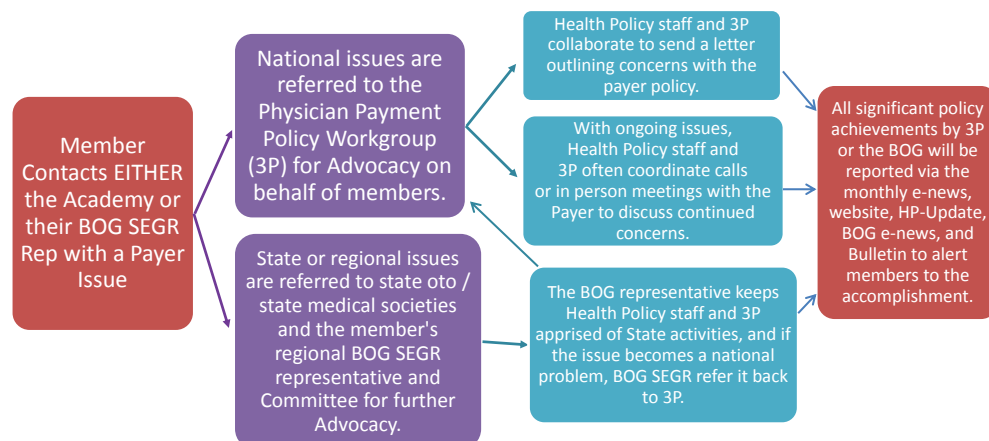
well as to assist members in furthering their relationships with payers and state OTO and medical societies in their regions and states.

We have also developed the 3P/BOG SEGR **communication flow chart**, which was approved by 3P and the BOG chairs, and outlines the socioeconomic issues that will be tackled by the BOG at the local level, or by 3P and the health policy team at the national level. On behalf of Academy 3P leaders, BOG leaders, and staff, we are thrilled about this new organizational structure for the BOG and look forward to future collaboration on socioeconomic issues affecting otolaryngology-head and neck surgery.

We hope this information and graphic are helpful in clarifying the roles of the BOG SEGR Committee and the 3P workgroup. Members with additional questions can email us at healthpolicy@entnet.org. Members can also access the resources mentioned above (flow chart and e-care package) at <http://www.entnet.org/Practice/businessofMedicine.cfm>. **b**

AAO-HNS REGULATORY, PAYER, ADVOCACY REQUEST REVIEW PROCESS

NATIONAL VS. LOCAL ISSUES



Experience the Annual Meeting

Your Academy Is Host to the World

Welcome! Benvenuto! Bienvenida!
Boa vinda! Herzlich willkommen!
Hos geldiniz! Karibu sana!
Mabuhay! Selamat Datang!
Soyez le bienvenue!

For more than a century, the American Academy of Otolaryngology—Head and Neck Surgery Foundation has stood at the forefront in developing innovative, evidence-based quality education for otolaryngologist-head and neck surgeons and otolaryngologic healthcare professionals worldwide. Through the Annual Meeting & OTO EXPOSM, the AAO-HNSF sets the highest standards for otolaryngology education.

Academy president **Richard W. Waguespack, MD**, welcomes U.S. and non-U.S. otolaryngologists alike, noting, “Our Academy mission is worldwide through its members. Aside from the 75 state and local societies in the U.S., there are 54 international corresponding societies around the world. Not only do these societies contribute to the Academy’s mission, they are also messengers of higher standards of medicine in the specialty for the nations of the world.”

The AAO-HNSF extends a special invitation to otolaryngology professionals worldwide to join us in Orlando, Florida, for the 2014 Annual Meeting & OTO EXPOSM. Now in its 118th year, the AAO-HNSF Annual Meeting is the largest gathering of otolaryngologist-head and neck surgeons in the world, providing unparalleled access to groundbreaking research, new guidelines, and the latest advances in the specialty. With all the AAO-HNSF has to offer, it’s no wonder that Annual Meeting attendees unanimously report that the knowledge they take from the meeting positively influences their practices.

2013 Annual Meeting Attendees Report

Alfred Sassler, MD, Cincinnati, OH
“It is always good to learn about new research and new trends that may challenge what we thought to be true.”

Michael Siegel, MD, Detroit, MI
“I have attended 22 AAO-HNS Annual Meetings, and each one is better than the last.”

Tripti K. Brar, MBBS, DNB, of New Delhi, India, reports, “The miniseminars and scientific sessions were highly informative and covered a vast array of topics. I took not only a lot of knowledge from the meeting, but also had the wonderful opportunity to establish professional relationships.”

Kapil Sikka, MBBS, MS, DNB, also of New Delhi, India, especially appreciated the high quality of the instruction courses: “The Academy helped the fellows in training like me immensely by allowing the provision of complimentary instructional course tickets, which I utilized to maximum benefit by attending a large number of courses.”

Andrew Scott, MD, Boston, MA
Pediatric Otolaryngologist; Assistant Professor, Tufts University School of Medicine “I have already used the information in my clinical practice.”

Exchange ideas and recharge your bond with our profession’s promise—all while discovering the latest innovations and resources for future growth. Use the connections you make and the knowledge you gain as a positive force in your career and for the health of your patients.

Leading-Edge Medical City

This year’s Annual Meeting will take place in Orlando, found in the “Sunshine

State”—Florida. With countless entertainment, dining, and shopping options combined with year-round sunshine, Orlando is the perfect event destination. Orlando was recently ranked by the Healthcare Convention & Exhibitors Association as the No. 3 destination for medical meetings. With the arrival of the Lake Nona Medical City, Orlando is preparing for the medical meetings of the future.

Inspired Attractions

Orlando certainly knows how to entertain, with seven of the world’s Top 20 theme parks in one destination, not to mention nearly 100 additional attractions. After walking the tradeshow floor, a leisurely escape to a world of imagination and fantasy will leave you feeling refreshed and inspired. Whether seeking to reconnect with childhood nostalgia or experience leading-edge innovations in ride technology, these latest additions are truly one of a kind. Just as an example and opening this summer at Universal Orlando Resort, the new Harry Potter-themed area will allow fans to ride the Hogwarts Express train and experience the British countryside just as the characters did in the book and movie series.

Dining and Entertainment Districts

Orlando is a true culinary hot spot with award-winning restaurants and celebrity chefs that cater to guests from across the globe. There’s an extensive menu of fine-dining establishments, international eateries, casual cafés, and chic wine bars for just about any taste or budget. Looking for an upscale steakhouse or a night of dancing? What about a jazz club or a new neighborhood bistro? Or want to check out where the locals wine and dine? Orlando has it all. The destination’s distinctive dining and entertainment districts include the Convention Area, Restaurant Row, Winter Park, Downtown, Universal/CityWalk, and Disney/Lake Buena Vista.

Unparalleled Education

Dates to Remember

May 5—Registration and Housing Opens

July 11—Early Registration Discount Deadline

August 22—Advance Registration Discount Deadline

September 21-24—AAO-HNSF Annual Meeting & OTO EXPOSM

The 2014 Annual Meeting education program will allow participants to hear from thought-provoking leaders on the most pressing issues currently confronting otolaryngology professionals. Last year, 87 percent of attendees indicated they would make changes in their practice based on what they learned at the Annual Meeting education sessions. Learn how to turn challenges into opportunities to advance patient care.

Divided by specialty tracks, the education program allows you to create your own customized experience:

- Business of Medicine/Practice Management
- Clinical Fundamentals (*Instruction Course only*)
- Facial Plastic and Reconstructive Surgery
- General Otolaryngology
- Head and Neck Surgery
- Laryngology/Broncho-Esophagology
- Otolaryngology/Neurotology
- Pediatric Otolaryngology
- Rhinology/Allergy
- Sleep Medicine

Scientific Program

The Annual Meeting's Scientific Program is composed of Scientific Oral Presentations, Miniseminars, and Scientific Poster Presentations. The Scientific Posters will be on display throughout the conference during registration hours. The Scientific

Oral Presentations and Miniseminars are included in the price of a full conference registration and take place starting at 10:30 am on Sunday and from 8:00 am to 12:00 pm Monday through Wednesday.

- **Scientific Oral Presentations**—A series of five-minute oral presentations that will take place within either 50- or 80-minute topical sessions that focus on cutting-edge clinical and translational basic research aspects of otolaryngology.
- **Miniseminars**—Presentations, case studies, and/or interactive discussions that will provide an indepth, state-of-the-art look at a specific topic.
- **Scientific Posters**—About 400 posters will be on display in Hall C.

Instruction Courses

Experts in the field of otolaryngology and other healthcare professionals present Instruction Courses. Early registration for these one- or two-hour courses increases the possibility of receiving your first-choice selections and saves you money. Instruction Course fees are \$50 an hour and \$70 an hour for hands-on courses, if you register before August 22. Instruction Course fees increase after the advance registration deadline to \$70 an hour, and to \$90 an hour for hands-on courses. There are four types of Instruction Courses:

- **Didactic Lecture**—Course will be presented in a large audience lecture setting.
- **Audience Polling**—Presentation would include the opportunity for audience members to respond to polling questions.
- **Hands-On**—Hands-On courses are classroom set and limited to 40 participants.
- **Mini-Course**—Mini-Courses promote informal discussion with the free exchange of information. These courses will be limited to 25 participants.

Credit Hours

AAO-HNSF designates this live activity for *AMA PRA Category 1 Credit*TM. Physicians should claim credit commensurate with the extent of their participation in the activity.



Sukgi Choi, MD

Coordinator, Instruction Course Program



Eben Rosenthal, MD

Coordinator, Scientific Program

- Scientific Program maximum: 13.5 credits

- Instruction Course maximum: 15 credits

Credit is awarded to physicians when documented by the submission of the 2014 Annual Meeting & OTO EXPOSM Evaluation.

New Beginnings in 2014

The 2014 Annual Meeting lives up to its cutting-edge reputation with a series of exciting enhancements to the program crafted by the two program committees. Offering a richer experience for the participants, these enhancements compliment the traditional program our attendees have honored throughout the years.

One of the most exciting revisions that will affect your travel plans is our change to the OTO EXPOSM and education program hours. Always respectful to your time out of the office and striving to maximize your experience, the OTO EXPOSM has been shortened to three influential days. The exhibit hall will now be open starting at 10:00 am on Sunday with its traditional grand opening and will close its doors at 3:00 pm on Tuesday afternoon.

The education program also has undergone an overhaul. Concluding at noon on Wednesday, the last day of the Annual Meeting will feature a morning program of Miniseminars, Oral Presentations, and Instruction Courses. This last day of the meeting is sure to be a whirlwind of activity with more opportunities to enrich your experience than ever before.

The Scientific Program features more opportunities for interaction. Now 25 percent of the Miniseminars will use audience response technology allowing you to respond to presenters' questions and instantaneously view your colleagues' answers. A few other highlights from the program include:

- The Martha Entenmann Tinnitus Research Center, Inc.: Abraham Shulman, MD and Barbara Goldstein, PhD; "Tinnitus Treatment Modalities and Neuromodulations: State of the Art 2014." Moderated by **Michael**

Hoffer, MD; and presented by **Michael D. Seidman, MD; Abraham Shulman, MD; Richard Tyler, MD; Berthold Langguth, MD**; and **Tobias Kleinjung, MD**, will speak to the neurobiology for all clinical types of tinnitus that is emerging and reflecting advances in the basic science and neuroscience of brain and brain function and the cochleovestibular system. As tinnitus types begin to be objectively identified in treatment, modalities can be applied in a more precise manner. The goal of this Miniseminar this to examine new and existing tinnitus specifically, in reference to how to apply these techniques of the different tinnitus types. Surgery, intratympanic treatment, neuromodulation, and magnetic stimulation will all be examined allowing the participants to understand the cutting edge of tinnitus therapy.



■ “The HPV Head and Neck Cancer Epidemic: What You Need to Know,” moderated by **Christin G. Gourin, MD** and presented by **Maie St. John, MD, Eduardo Mendez, MD, MS, Harry Quon, MD,** and **Mariam N. Lango, MD,** will address the HPV-associated head and neck cancer as an epidemic striking a younger and healthier population without the usual risk factors for head and neck cancer. Most patients have an excellent prognosis following treatment with surgery or chemoradiation, and the sequel of long-term morbidity from treatment are of increasing concern as patients are expected to live long enough to experience complications. Failure to identify a subset of high risk patients at risk for metastasis, recurrence, and decreased survival can lead to under treatment and poor outcomes. This Miniseminar will discuss the epidemiology, workup, treatment, and surveillance of HPV+ head and neck cancer.

The Instruction Course program includes three MOC Review Courses—“Head and Neck Surgery,” “Rhinology,” and “General Otolaryngology.” These extended courses, two- and three-hours long, meet MOC Part III requirements. The program also features a Clinical Fundamental track complying with MOC Part III requirements to meet your recertification needs. Responding to your requests for additional hands-on opportunities, we’ve added an additional hands-on room this year that will give you ample time to interact with expert faculty while participating in cutting-edge demonstrations.

“ACS Ultrasound Course: Thyroid and Parathyroid Ultrasound Skills-Oriented Course” with **Robert A. Sofferman, MD,** course director, will take place from 8:00 am-4:30 pm Saturday, September 20.

Additional fees apply.

Bringing the Best Together

Because our meeting is the largest gathering of otolaryngologists worldwide—about 40 percent of physician attendees are international, coming from 90 or more countries—we do all we can to make it user-friendly for our many international visitors.

Guyan A. Channer, MD, of Kingston, Jamaica, says, “I was particularly impressed with the meeting’s technological resources, where I seamlessly pre-planned my daily schedule using wireless apps and made contact with various manufacturers.”

Professor Yongxiang Wei, MD, of Shenyang, China, adds, “Professional website, free Wi-Fi, accommodations, information and food services, traffic, technique support for audios and videos et al., were all very well organized.”

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Education Program Is Truly International

International presenters are a huge part of the meeting's educational program: a stated goal of the meeting is "to develop a broader understanding of approaches used in the practice of otolaryngology-head and neck surgery in countries outside the U.S." International submissions for miniseminars and oral and poster presentations participate on an equal footing in the peer-reviewed process. Our Scientific Program is a venue for the many international presenters for both oral presentations and posters. The program provides a platform for new collaborative activities, such as our participation in the Cochrane Collaborative on Evidence Based Medicine.

OTO EXPOSM—A Better Mousetrap

As the adage says, "Build a better mousetrap and the world will beat a path to your door," so specialists from around the world flock to our OTO EXPOSM to examine, test, and compare the myriad products and services on display. **Hideaki Moteki, MD, PhD**, of Matsumoto, Japan observed, "In the OTO EXPO, there were a huge number of booths and products, and I was very excited about seeing advanced products that I had never seen before."

Experience It for Yourself

In sum, no other otolaryngology meeting in the world compares to the number and variety of attendees that the Annual Meeting attracts. With its multidisciplinary focus, the education offered draws attendees from across the health spectrum and from around the world. They all belong to a worldwide community whose goal is to provide the best patient care. Your Academy is more than a national professional association; it is your global network working for the best ear, nose, and throat care. Join us in Orlando for this unrivaled experience. 



Reasons to Book in the Room Block and Not Online

- Fast, easy, and secure online booking
- Complimentary shuttle service between hotels not within walking distance to the convention center
- Top-notch service support
- No service fees to make your reservations
- Immediate confirmations—no waiting or wondering
- Update our reservations with no fees or penalties.

Take time to explore the OTO EXPOSM during the NEW hours:

Sunday,
September 2110:30 am-5:00 pm

President's
Reception6:00-7:30 pm

Monday,
September 228:00 am-5:00 pm

Tuesday,
September 238:00 am-3:00 pm

Exhibitors in the OTO EXPOSM help the physician and otolaryngology medical professionals reach the ever-growing assortment of otolaryngologic products and services. The OTO EXPOSM is an extension of the educational sessions, where attendees come for face-to-face interaction with product experts.



Interested in Holding a Meeting or Reception at the Annual Meeting?

Fill out a meeting space application today! Visit www.entnet.org/annual_meeting to find the application. Benefits to holding a meeting through AAO-HNSF:

- Published Events—Meeting/event is published online and in the final program read by all attendees
- Convenience—Ease of being able to meet near the conference activities
- Experienced—Experienced staff work with you on your meetings/events

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On Volunteering and Philanthropic Giving

Sujana S. Chandrasekhar, MD

At AAO-HNS/F headquarters, a long glass wall highlights otolaryngologists and their families who have donated substantial sums. They and other donors support the breadth of activities. Otolaryngology colleagues volunteer their time and energy to: write articles for the *Bulletin*, serve on Academy/Foundation committees, write Clinical Practice Guidelines and Consensus Statements and provide content for teaching materials.

How do they find the time? Why do they contribute? Should you join them?


They are busy clinical otolaryngologists like you and me, whose professional and personal lives are brimming with activities. I know because plenty of committee phone calls are taken by Academy members at their kid's soccer games, on their way to family events, from overseas on humanitarian missions, or just trying to squeeze in a haircut at day's end. Some have partners; some have children; some care for adult relatives; some don't. All have a passion

for volunteering to enhance otolaryngology care. No-one has the time, really, in their schedules. But they make the time and manage it so that they can give 100 percent to their practice, 100 percent to their family, and 100 percent to the Academy.

The really interesting question is, why? I am in solo private practice with a husband and four children. My oldest will be starting college in the fall. Our family relies on both incomes. When I talked to a colleague about the Hal Foster, MD Endowment, he initially couldn't understand how or why I would divert monies from my family. But then he looked into it, and he donated, too. Are we just crazy? Well, maybe, but research actually shows that Spending Money on Others Promotes Happiness (Dunn EW, *Science*, 2008). There is also sizeable evidence that charitable giving also makes the giver prosperous. The Social Capital and Community Benchmark Survey (SCCBS, 2000) of 30,000 observations from 41 communities and 29 states showed that a \$1 increase in charitable giving leads to an average \$3.75 increase in household

income (Brooks AC, *J Econ & Fin*, 2007). In addition, givers were 25 percent likelier to report excellent or very good health, while 50 percent of non-givers self-reported health as fair or poor.

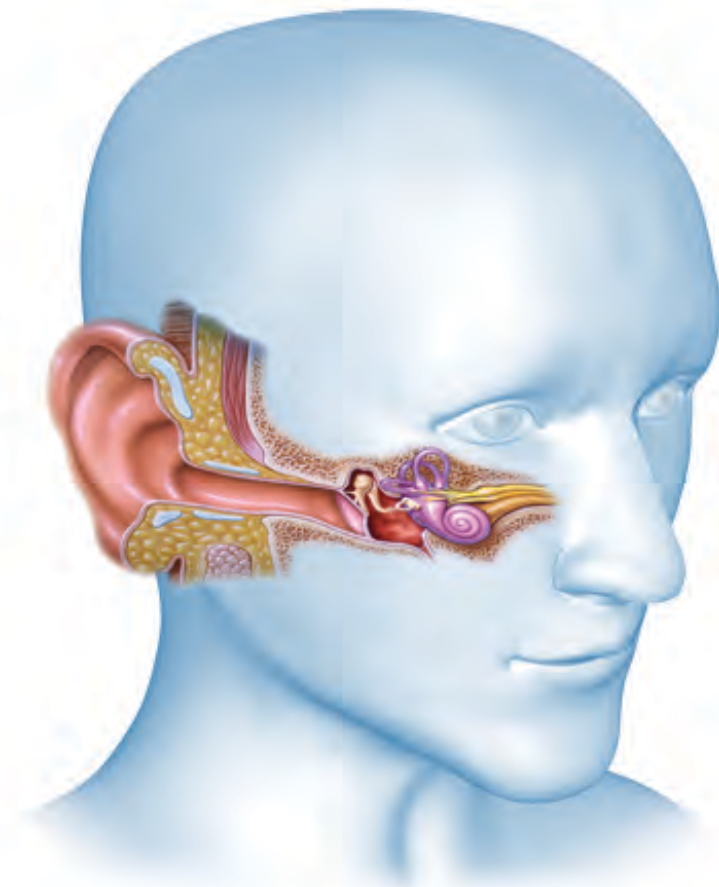
Okay, but what about that most precious commodity, time? The SCCBS showed that volunteers were 29 percent likelier to self-report health as excellent or very good, while non-volunteers were 71 percent likelier to say fair or poor. And volunteers may even live longer. (http://www.nationalservice.gov/pdf/07_0506_hbr.pdf)

When people give their time or money to a cause they believe in, they become problem solvers, which makes them happier than bystanders and victims of circumstance. (Brooks, *NY Times*, 2014) There is a virtuous cycle: happy, healthy, successful people are more likely to give and volunteer, and simultaneously, charitable people are more likely to be happy, healthy, and wealthy. So, if you're considering volunteering your time and/or giving to the AAO-HNS/F, jump on in—the water's fine and it just might be good for your health, too. 

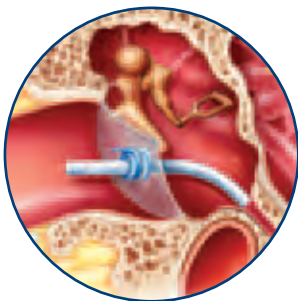


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Health Policy 101: Working for You

The Academy's Physician Payment Policy (3P) Workgroup is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding and reimbursement, and practice services or management. 3P and the Health Policy staff work to ensure that members' interests are appropriately represented. 3P oversees the review and content for the Clinical Indicators and the Position Statements, and provides resources to members such as template appeal letters and CPT for ENT coding guidance articles. Coordination with other Academy committees, subspecialties, and medical specialty societies are critical to 3P's success.

Health Policy has two coordinators, who are also the Physician Payment Policy (3P) Workgroup co-chairs.

James C. Denneny III, MD, coordinator for Socioeconomic Affairs. Dr. Denneny oversees all coding and payment issues related to Medicare and the Academy's efforts to influence the CPT coding and Relative Value System (RVS) through work with the Academy's

Members and Advisors on the AMA's CPT Editorial Panel, the Relative Value Update Committee (RUC), and the RUC's Practice Expense Subcommittee. He works closely with the Health Policy department to achieve these directives.

Dr. Denneny is on the Socioeconomics Committee of the Board of Governors of the American College of Surgeons (ACS) and the Executive Committee of the Board of Governors of the ACS. These positions offer synergistic opportunities to increase cooperation and build coalitions among the surgical societies as we navigate an increasingly hostile landscape for physicians, particularly surgeons.

Jane T. Dillon, MD, MBA, coordinator for Practice Affairs. Dr. Dillon is responsible for developing and maintaining programs that support and provide practice management-related answers to health policy issues. She spearheads collaborative efforts with other specialty societies on priority payer reimbursement issues related to private national insurance policies, publication of the 2014 Socioeconomic

Survey, and provides input on any health policy related health policy educational programs for the Annual Meeting.

In addition, the coordinator for Practice Affairs is responsible for publishing periodic practice management articles for the Academy's monthly *Bulletin*. Stay tuned for upcoming articles focused on these issues. Dr. Dillon works closely with Dr. Denneny to ensure high quality programs for delivery to both the Board of Directors and members. Finally, they both work collaboratively with other Academy leaders from Research and Quality, the Board of Governors, and Socioeconomic and Grassroots Affairs (SEGR) Committee (see related article on page 9), and the Board of Directors to review potential prospective payment models for possible use by otolaryngology-head and neck surgeons in the future.

More Examples of Health Policy Efforts for Members

■ Regulatory Advocacy: Cerumen Removal



Academy Works to Resolve Concerns Related to CMS 2014 Payment Policy for Removal of Cerumen (69210)

In February, the Academy conducted a conference call with CMS regarding its reimbursement policy for cerumen removal, CPT 69210, after hearing from Academy members who had experienced issues with billing 69210 using the -50 modifier. Per CMS instruction on the call, this reimbursement policy that only pays for one unit regardless of whether the service is performed bilaterally will remain in place through CY 2014 as an interim value for the service, which was included in the Final Medicare Physician Fee Schedule (MPFS) for 2014. **Based on CMS' guidance, the Academy recommends that members NOT report 69210 using modifier -50, as MACs are denying these claims entirely and not paying for even one unit reported. This requires providers to reprocess the denied claim, which takes additional time and administrative effort. CMS**

has stated it will not issue a transmittal to providers at this time, and has asked the Academy to share this coding directive with members. We are working with the Agency to provide them with concrete data related to the percentage of time 69210 is provided bilaterally, in hopes that this will allow them the necessary evidence to revisit this payment policy in CY 2015. As the dialogue continues with CMS, we will keep members apprised of our progress on these advocacy efforts via the weekly e-news, monthly HP Update, and printed *Bulletin*. Please email us with any questions at healthpolicy@entnet.org.

Please email us with any questions at healthpolicy@entnet.org.

■ Private Payer Advocacy: Sinus Ostial Dilation and Imaging Services

Academy Continues Efforts to Expand Coverage of Balloons for Dilation of Sinuses and Reverse Experimental/Investigational Coverage Decisions for Computer Assisted Surgical Navigation (CASN)

The Health Policy team recently sent comment letters to more than 10 private payers in an effort to change their respective medical policies regarding the use of balloons as a tool in the standard approach to sinus ostial dilation. The letters highlight the recently revised and updated position statement on "Dilation of Sinuses, Any Method" (e.g., balloon, etc.), which incorporates updated references, most notably three recently published randomized control trials (RCTs). View the updated position statement at <http://www.entnet.org/Practice/Balloon-Dilation.cfm>.

The Academy submitted comments to the Humana Medical Director

regarding their medical policy on Computer Assisted Surgical Navigation (CASN), which does not currently provide payment for the service. We responded to Humana's request for additional evidence with the new references included in our newly updated position statement on Intra-Operative Use of Computer Aided Surgery.

■ Practice Management

Coding Corner

The Academy offers members a wealth of coding and practice management resources, which are available to you at <http://www.entnet.org/practice/codingResources.cfm>.

We also recommend checking the coding resources provided by the AMA and ACS. (The AMA CPT Network can be accessed at https://commerce.ama-assn.org/store/content/cptnetwork?node_id=nn407.)

NOTE: Due to concerns regarding liability, the Academy is unable to provide members with individualized advice on billing and coding issues.


Socioeconomic Survey

The Health Policy department oversees the distribution and analysis of the AAO-HNS Socioeconomic Survey, which was distributed to members in March. This effort, overseen by Dr. Dillon as coordinator for Practice Affairs, collects information on members' practice patterns, the healthcare environment, and future trends in otolaryngology-head and neck surgery. Results of the survey will be on display at the AAO-HNSF 2014 Annual Meeting & OTO EXPOSM in Orlando, Florida, September 21-24.

CMS Quality Reporting Initiatives Fact Sheets

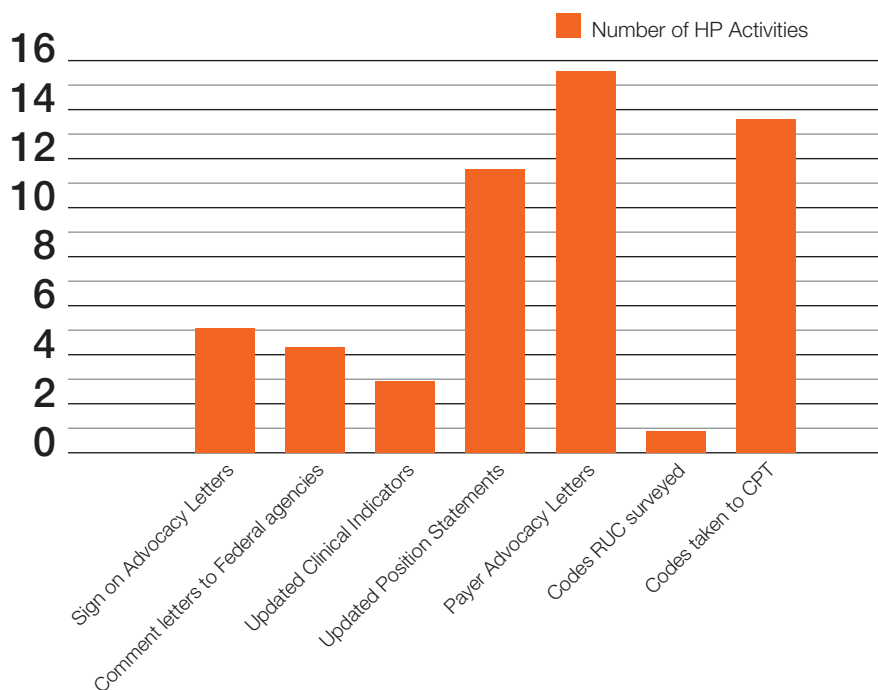
This is a pivotal year for physicians as the CMS has begun applying penalties across three of its quality initiatives. In 2015, physicians will be subject to financial penalties, known as payment adjustments, for the first time for the Electronic Health Record (EHR) Meaningful Use Incentive Program and Physician Quality Reporting System (PQRS). The 2015 EHR and PQRS penalties are based

on participation and reporting in 2013. Penalties also increase for failing to participate and meet the e-Prescribing (eRx) Incentive Program reporting criteria in 2013. To help you understand the reporting requirements for these quality initiatives, the Academy's Health Policy department has created one-page fact sheets for each of the CMS initiatives. These fact sheets follow this article and

include a brief overview of the program; provide information on how you and your practice can successfully meet the reporting criteria, earn incentives, and avoid payment reductions; and direct you to additional resources to help you. For information on all of these programs, visit the Academy's CMS Quality Initiatives webpage at <http://www.entnet.org/Practice/CMSpenalties.cfm>. 

■ For more on additional Health Policy activities, see the table below.

Health Policy Activities Since Annual Meeting 2013



Health Policy Abbreviations

- 3P Workgroup—AAO-HNS Physician Payment Policy (3P) Workgroup
- AMA—American Medical Association
- ASC—Ambulatory Surgical Center
- CAC—Medicare Contractor Advisory Committee
- CPT code—Current Procedural Terminology
- CMS—Centers for Medicare & Medicaid Services
- EHR/EMR—Electronic Health/Medical Record
- OPPTS—Hospital Outpatient Prospective Payment System

- ICD-9/ICD-10—International Classification of Diseases, with n = 9 for Revision 9 or 10 for Revision 10; with CM = Clinical Modification; and with PCS = Procedure Coding System.
- MAC—Medicare Administrative Contractor
- MPFS—Medicare Physician Fee Schedule
- MU—Meaningful Use
- PQRS—Physician Quality Reporting System
- RUC—Relative Value Scale Update Committee
- RVU—Relative Value Unit
- VBM—Value-Based Payment Modifier

Health Policy Glossary Resource: <http://www.cms.gov/apps/glossary/default.asp?Letter=A&Language=English>



Electronic Health Records Incentive Program



AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

Successfully Navigating the Centers for Medicare & Medicaid (CMS) Electronic Health Records Incentive Program

◆ What Is the EHR Incentive Program?

The Electronic Health Records (EHR) Incentive Program is a CMS initiative designed to facilitate the use of EHRs in clinical settings. Providers who demonstrate that they are using their EHRs in ways that can positively impact quality of care are entitled to incentive payments. By meeting the objectives outlined by CMS, Eligible Professionals (EPs) demonstrate “meaningful use” (MU) and potentially avoid the penalties set to begin in 2015. The program has 3 Stages: Stage 1; Stage 2, currently under way; and Stage 3, set to begin in 2016.

◆ EHR/Meaningful Use Incentives and Penalties in 2013 and Beyond

	2013	2014	2015	2016	2017
Incentive Amount	\$8K-\$15k	\$4K-\$12k	\$2K-\$8k	\$2K-\$4k	N/A
Penalty Amount	N/A	N/A	-1% (based on 2013 reporting)	-2% (based on 2014 reporting)	-3% (based on 2015 reporting)

◆ How to Earn Incentive Payments

1. Determine if you are an eligible professional for the program and register for the program at <https://ehrincentives.cms.gov>
2. Purchase an Office of the National Coordinator (ONC) Health IT Certified EHR System. A list of Certified EHRs can be found here: <http://oncchpl.force.com/ehrcert>
3. Report the required number meaningful use objectives (Core Objectives + Menu Objectives) PLUS the required number of clinical quality measures (CQMs). Meet the reporting period requirements.
 - a. For your first year, report data from any continuous 90-day period during the calendar year (any 90 continuous days from January 1st to December 31st).
 - b. After your first year, report for the entire calendar year (Jan. 1 to Dec. 31, 2013 for example.) Special Note for 2014: All providers, regardless of their stage of MU, are only required to demonstrate MU for a 90-day EHR reporting period because all must upgrade or adopt newly certified EHRs in 2014.

◆ How Does STAGE 2 Differ from STAGE 1?

STAGE 1

- Report on 13 core objectives
- Report on 5 of 10 menu objectives
- Report on 6 out of 44 CQMs

STAGE 2

- Report on ALL 17 core objectives
- Report on 3 of 6 menu objectives*
Note: If none of the menu objectives are applicable to your scope of practice & you qualify for all of the exclusions for each, then you can select 3 and claim the exclusion for each.
- Report on 9 out of 64 CQMS*.
The CQMs selected must cover at least 3 of the 6 available National Quality Strategy domains.

Note: EPs cannot earn incentives in both the EHR Meaningful Use and Electronic Prescribing Incentive Programs

◆ How to Avoid Penalties

1. EPs must meet the Meaningful Use criteria above (20 Core and Menu Objectives and 6 Clinical Quality Measures over the reporting period) or;
2. Qualify for an exemption for 2014 reporting requirements. Exemptions are granted on an annual basis and must be applied for annually.

Continued on back





Electronic Health Records Incentive Program



AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

Successfully Navigating the Centers for Medicare & Medicaid (CMS) Electronic Health Records Incentive Program *Continued*

EHR Program Changes for 2014

- ◆ ALL providers must adopt the 2014 Edition CEHRT to demonstrate MU, regardless of the stage in which they're currently participating.
- ◆ EHR technology that is certified to the 2014 standards will contain new CQM criteria, and EPs will report using the new 2014 criteria regardless of their stage.
- ◆ Special Reporting Period: All providers are only required to demonstrate MU for a 90-day EHR reporting period because all must upgrade or adopt newly certified EHRs in 2014:
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1ChangesTipsheet.pdf>
- ◆ EPs have the option to electronically report CQM data for the full calendar year of 2014 to receive credit for both the PQRS program and EHR Incentive Program

Important Dates for 2014

- ◆ March 31st: Attestation Deadline for EPs for the 2013 program year!
- ◆ September 30th: End of 2014 reporting period for eligible hospitals!
- ◆ November 30th: Attestation Deadline for EHs for the 2014 program year!
- ◆ December 31: End of 2014 reporting period for EPs!



Electronic Prescribing Incentive Program



AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

Successfully Navigating the Centers for Medicare & Medicaid (CMS) Electronic Prescribing Incentive Program

◆ What Is the eRx Incentive Program?

The Electronic Prescribing (eRx) Incentive Program is a CMS reporting program that uses a combination of incentive payments and payment adjustments (penalties) to encourage electronic prescribing by eligible professionals. The program provides an incentive payment to practices with eligible professionals (EPs) (identified on claims by their National Provider Identifier [NPI] and Tax Identification Number [TIN]) who successfully e-prescribe for covered Medicare Physician Fee Service Schedule (MPFS) services for Medicare Part B Fee-for-Service (FFS) beneficiaries.

◆ eRx Incentives and Penalties in 2014 and Beyond

	2014	2015
Incentive Amount	N/A	N/A
Penalty Amount	-2%	TBD in future rule making

◆ 2014: How to Avoid Penalties

1. Determine if you successfully electronically prescribed during the 2012 eRx 12-month reporting period, which was from January 1, 2012 to December 31, 2012; OR
2. Determine if you successfully electronically prescribed during the 2013 eRx 6-month reporting period, which was from January 1, 2013 to June 30, 2013; OR
3. Qualified and requested a 2013 eRx significant hardship exemption, or submitted a lack of prescribing privileges G-code request.*

* Exemptions include:

- a. Practice in a rural area without adequate high-speed internet access
- b. Practice in a location without enough available pharmacies for e-prescribing
- c. Physicians who are unable to electronically prescribe due to local, State, or Federal law or Regulation
- d. Physicians who infrequently prescribe
- e. Insufficient opportunities to report the e-prescribing measure due to program limitations
- f. Successfully achieve Meaningful Use in the CMS Electronic Health Record (EHR) Meaningful Use Incentive Program
- g. Demonstrate intent to participate in the EHR Incentive Program for the first time by registering for the program and adopting certified EHR technology

Please Note: If you are unsure if you have met the reporting requirements and/or an exemption, please contact the CMS' QualityNet Help Desk as they can assist members on an individualized basis. The contact information for the QualityNet Help Desk is: Phone: 866-288-8912, Fax: 888-329-7377, Email: qnetsupport@sdps.org

Important Facts about eRx in 2014

- ◆ 2013 reporting year was the last year to report for the eRx program
- ◆ 2014 will be the last eRx payment adjustment (this may be subject to change in future rulemaking)
- ◆ Reporting G code (G8553) as a means of qualifying for the incentive, and thus avoiding penalties in 2014 is no longer applicable in 2014. In other words, there is not a replacement code for the G8553. However, e-prescribing is still an aspect of Meaningful Use reporting, so you will want to ensure that you are meeting all of the requirements for that reporting program. Please refer to the EHR Information Center at 888-734-6433 for more information on that program.



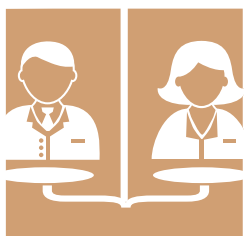


Successful Participation in the Physician Compare Program: What the Web Says About You as a Physician

◆ What Is Physician Compare?

Physician Compare is a Centers for Medicare & Medicaid Services (CMS) website that allows the public to find and select physicians who are currently enrolled in the Medicare program as well as other information on Eligible Professionals (EPs) who participate in CMS quality programs. Information on physician performance, including information on quality measures and patient experience, is available to the public through the Physician Compare website.

◆ General Physician Information Included on Physician Compare includes:



- Address
- Education
- American Board of Medical Specialties (ABMS) Board Certification Information
- Primary and Secondary Specialties
- Group Affiliations
- Hospital Affiliations (which link to the hospital's profile on Hospital Compare as available)
- Medicare Assignment Status
- Provider Language Skills

◆ Physician Participation in Physician Compare:

- Physician Quality Reporting (PQRS), including the Group Practice Reporting Option (GPRO)
- Electronic Prescribing (eRx) Incentive Program
- Electronic Health Record (EHR) Meaningful Use (MU) Incentive Program

If you would like to check your information for accuracy, please visit: <http://www.medicare.gov/physiciancompare/search.html>.

◆ PHYSICIAN COMPARE PUBLIC REPORTING TIMELINE

2013	2014	2015
<ul style="list-style-type: none"> • 2011 PQRS, GPRO, eRx & EHR MU Incentive Program Participation • 2012 PQRS, GPRO, eRx & EHR MU Incentive Program Participation • Information on ABMS board certification 	<ul style="list-style-type: none"> • 2013 PQRS, GPRO, eRx & EHR MU Incentive Program Participation • 2013 PQRS Maintenance of Certification Incentive • 2012 PQRS GPRO & ACO measures (early 2014) • 2013 PQRS GPRO & ACO measures (late 2014) • GPRO Composite Measures (DM & CAD) (late 2014) • CG-CAHPS data for PQRS GPROs and ACOs (late 2014) • Successful reporting of the 2013 Cardiovascular Prevention measures group in support of Million Hearts Initiative 	<ul style="list-style-type: none"> • 2014 PQRS, GPRO, eRx & EHR MU Incentive Program Participation • 2014 PQRS Maintenance of Certification Incentive • 2014 PQRS GPRO & ACO measures • CG-CAHPS data for PQRS GPROs and ACOs • 2014 Individual PQRS Quality Measures • Measures from the 2014 Cardiovascular Prevention measures group in support of Million Hearts Initiative • Specialty Society Measures (beyond 2015)

If members would like to provide feedback about the Physician Compare website, feedback can be sent to PhysicianCompare@Westat.com

◆ How Do I Update My Information on Physician Compare?

Incorrect information relating to address, education, contact information, and Medicare assignment status needs to be edited through the Internet-based PECOS system at <https://pecos.cms.hhs.gov/pecos/login/do>. Incorrect information relating to training, residency, hospital affiliation and/or foreign language needs to be edited by email to Physician Compare at PhysicianCompare@westat.com. Please be sure to include your name, specialty, address of practice location, NPI number, and the best method of contact in addition to providing the corrected information.





Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS)

◆ What Is PQRS?

PQRS is a CMS reporting program that uses a combination of incentive payments and penalties (payment adjustments) to promote reporting of quality information by physicians and other health professionals. Prior to 2010 the program was known as the Physician Quality Reporting Initiative (PQRI).

◆ PQRS Incentives and Penalties in 2014 and Beyond

	2013	2014	2015	2016
Incentive Amount	0.5%	0.5%		
Penalty Amount			-1.5% (based on 2013 reporting)	-2% (based on 2014 reporting)

◆ How to Earn an Incentive Payment in 2014

1. Decide whether to report as an individual or as a group practice (group reporting is now available to practices with 2 or more eligible professionals)
2. Determine which reporting mechanism you will use to report, in 2014 there are 6 options:
 - a. Claims-based reporting
 - b. Registry-based reporting, such as PQRIwizard: <https://aaohns.pqriwizard.com/default.aspx>
 - c. EHR direct vendor or EHR data submission vendor reporting
 - d. Group Reporting via the Group Practice Reporting Option (GPRO) (applies to groups of 25 eligible providers (EPs) or more)
 - e. The new Qualified Clinical Data Registry (QCDR) Option
 - f. Groups of 25+ may also use a combination of the options above in conjunction with reporting on the CG CAHPS survey measures via a CMS-certified survey vendor, to earn an incentive.
3. Decide whether to report on individual quality measures (a minimum of 3 individual measures must be reported to avoid a payment penalty, but 9 individual measures must be reported to obtain the incentive payment for 2014) or a measures group (note you must report on all measures in a measures group to be successful).
4. Choose to report over a 12 month (Jan. 1 – Dec. 31) or 6 month (Jul. 1 – Dec. 31) period

Note: The reporting requirements to become eligible for an incentive differ by the reporting mechanism and type of measures selected (individual measures versus a measures group). 2014 reporting requirements are available at <http://www.entnet.org/pqrs>

◆ How to Avoid the 2016 Penalty

To avoid the 2016 penalty physicians must report quality measure data to CMS for PQRS during the 2014 reporting period. To avoid the 2016 penalty you can:

1. Earn a 2014 PQRS incentive payment (as outlined above)
2. Submit data to CMS on 3 individual measures
3. Successfully report via the GPRO options for groups

Continued on back





Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS) *Continued*

PQRS Changes for 2014

- ◆ CMS finalized 285 individual measures for inclusion in the 2014 PQRS program, including 4 of the Academy's Sinusitis Measures for inclusion in 2014 and beyond.
- ◆ CMS responded to our inquiry as to why this was only approved for reporting via registry and stated that for all new measures they are approved for registry only initially, however, they will continue to work toward complete alignment and if possible will include this measure for EHR-Based reporting in the future.
- ◆ Currently, the minimum number of measures in a measure group, remains at four measures for CY 2014. CMS plans to increase this minimum number in the future. CMS will likely work with the measure developers and owners of measures groups to appropriately add additional measures to measures groups that only contain four measures.
- ◆ CMS also finalized the new Patient-Centered Surgical Risk Assessment and Communication measure for reporting via registry or measures group in 2014.

Please refer to the our website for information on additions/deletions of measures for 2014:

<http://www.entnet.org/Practice/qualityimprovement/cmsPQRS.cfm>

CMS Changes to Reporting Methods for CY 2014

- ◆ CMS eliminated the option to report measure groups via claims for individual EPs in CY 2014. Individuals may now ONLY reporting measure groups via registry.
- ◆ CMS reduced the percentage of patients EPs must report on using Registry reporting from the previous 80% to 50% for CY 2014 reporting. This is now consistent with the patient threshold requirements for reporting via claims.
- ◆ CMS has increased the number of measures Individual EPs must report on from the prior 3 to 9 measures (across 3 quality domains, for 50% of beneficiaries) for CY 2014 reporting. EPs who report on less than 9 measures will be subject to the an additional process called Measure Applicability Validation (MAV process) to ensure that there were not any other measures they should have, or could have, reported on. The increased measure requirement applies to EPs reporting via claims, registries, and EHR; however, the exception to avoid the penalty is only applicable to claims and registry reporting.
- ◆ CMS finalized the new Qualified Clinical Data Registry (QCDR) reporting option for individual reporting in CY 2014.
- ◆ CMS finalized exceptions for individuals reporting via Claims and Registries for CY 2014 to avoid 2016 payment penalty. These EPs will not be eligible for the 2014 bonus payment, however. See detail below.

Changes to Group Reporting in CY 2014

- ◆ CMS revised the deadline by which Group Practices choosing to report for PQRS via the Group Practice Reporting Option (GPRO) must self-nominate from the previous October 15th of the reporting year, to a new deadline of September 30th of the reporting year.
- ◆ CMS finalized a new group reporting option for groups of 25-99 EPs to report, via a CMS-certified survey vendor, on the CG-CAHPS survey measures. Groups selecting this reporting option will need to report using additional reporting methods in order to report on additional measures to meet the criteria for satisfactory reporting for CY 2014.
- ◆ CMS added the requirement for CY 2014 that groups of 25+ who wish to report the CG-CAHPS patient satisfaction survey measures must indicate their intent to do so when they register for the PQRS program. CMS also finalized a change to utilize a single website for Groups to self-nominate to use the GPRO reporting option as well as indicate they would like to report on CG-CAHPS measures for CY 2014.
- ◆ CMS added the requirement that groups of 100+ must report on all CG-CAHPS measures as well as the GPRO measures in the web interface.





Value Based Payment Modifier



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Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Value Based Payment Modifier (VM)

◆ What is the Value Based Payment Modifier (VM)?

The VM assesses both quality of care furnished, and the cost of that care, under the Medicare Physician Fee Schedule (MPFS). CMS has begun with a phase-in of the VM in 2015, which will be completed by 2017. Implementation of the VM is based on participation in Physician Quality Reporting System (PQRS). In 2013, the VM applied to groups of physicians with 100 or more eligible professionals (EPs). In CY 2014, CMS is expanding this to groups with 10 or more EPs.

◆ Overview of VM Program in 2013 and 2014 Reporting Periods

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies (take effect in 2014)
Performance year	2013	2014
Group Size	100+	10+
Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, OR 50% of EPs reporting individually <i>**Note: CMS expects to raise this % threshold in future years**</i>
Quality / Outcome Measures	<ul style="list-style-type: none"> Measures reported through the GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 70% of the EPs within the group All Cause Readmission Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes) 	<p>These requirements are the same for CY 2014 reporting, however, CMS also:</p> <ul style="list-style-type: none"> Finalized that groups of physicians with 25 or more eligible professionals will be able to elect to have the patient experience of care measures collected through the PQRS CAHPS for CY 2014 included in their payment modifier for CY 2016. If all the EPs in the group satisfactorily participate in a PQRS qualified clinical data registry in CY 2014 and CMS cannot receive quality performance data from such registry, CMS will classify the group's quality composite score as "average" because they would not have data to reliably indicate whether the group should be classified as high or low quality.
Patient Experience Measures	N/A	PQRS CAHPS: Option for groups of 25+ EPs
Cost Measures	<ol style="list-style-type: none"> Total per capita costs measure (annual payment) standardized and risk-adjusted Part A and Part B costs) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, CAD, Diabetes 	Same as 2015 and Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
Benchmarks	Group Comparison	Specialty Adjusted Group Cost CMS also finalizes a specialty adjustment that allows for peer group comparisons related to the new cost measure for CY 2015.
Quality Tiering	Optional	Mandatory Groups of 10-99 EPs receive only the upward or neutral adjustment, no downward adjustment. groups of 100+ are subject to an upward, neutral or downward adjustment. <i>**Note: Groups of 100+ that furnish high quality care at high cost, for CY2014 reporting, will not be subject to a payment penalty.**</i>
Payment at Risk	-1.0%	<p>-2% if you do not participate in PQRS</p> <p>-2% if you are 100+ and provide low quality/high cost care</p> <p>-1% if you are 100+ and provide either low quality/average cost or average quality/high cost care.</p>
Physician Feedback Reports (QRURs)	Reports sent to 24,000 providers in Iowa, Kansas, Missouri and Nebraska.	On September 16, 2013 groups with 25+ EPs received Quality Resource Use Reports (QRURs) which reflect their performance on quality and cost reporting measures based on their 2012 PQRS reporting. All physicians can expect QRURs in late summer of 2014

Continued on back



Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Value Based Payment Modifier (VM) *Continued*

◆ How are my Quality and Cost Scores Calculated?

Quality Scores are comprised of:

- Clinical care
- Patient experience
- Population / community health
- Patient safety
- Care coordination
- Efficiency

Cost Scores are comprised of:

- Total per capita costs (plus Medicare Spending Per Beneficiary)
- Total per capita costs for beneficiaries with specific conditions

Each group then receives two composite scores (quality and cost), based on the group's standardized performance (e.g. how far away from the national mean). Group cost measures are adjusted for specialty composition of the group. This approach identifies statistically significant outliers and assigns them to their respective quality and cost tiers.

Quality / Cost	Low Cost	Average Cost	High Cost
High Quality	+2.0	+1.0x*	+0.0%
Medium Quality	+1.0x*	+0.0%	-1.0%
Low Quality	+0.0%	-1.0%	-2.0%

*Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score is in the top 25% of all beneficiary risk scores.

◆ How are Patients Attributed to my Group for Purposes of Cost Calculation?

Step 1: Identify all beneficiaries who have had at least one primary care service rendered by a physician in a group.

Step 2: Assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.

Step 3: For beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any EP.

Exclusions: Patients that are part year beneficiaries (including those new to Medicare), died during the year, or had one or more months of Medicare Advantage are excluded from the attribution for calculating costs.

◆ What Role do the Physician Feedback (QRURs) Reports Play in This?

The QRUR reports distributed by CMS to physicians play a crucial role in informing providers and groups impacted by the VM on areas that present opportunities for improvement as it relates to their quality and cost scores. The bottom half of the timeline below shows when the reports are released and who will receive them. Those groups (25+ EPs) receiving the reports in September of this year will notice new features in the report, including:

- Drill down table including all beneficiaries attributed to the group, their resource use, specific chronic disease
- Drill down table including all hospitalizations for attributed beneficiaries
- Drill down table of individual EP PQRS reporting (December 2013)

All groups and solo practitioners will receive QRURs in late summer of CY 2014

◆ What groups of 10+ EPs need to do to be successful in CY 2014?

Step 1: Choose a PQRS Reporting Mechanism

- Web interface (GPRO)- Group must self-nominate/ register (May 2014- September 2014)
- CMS Qualified Registry (such as the Academy's PQRSWizard)
- EHR
- Utilize 50% Individual Reporting Option

Under the individual reporting option, each provider in your group can choose how they wish to report on PQRS. All measure performance for the group is then rolled together and 70% of the EPs in the group must meet PQRS criteria for CY 2016 payment adjustment in order to meet the 2016 VM requirements. Groups do not have to self-nominate for this option. Individuals can report via Claims, EHR, CMS Qualified Registries, or new Qualified Clinical Data Registries (QCDRs).

Visit our VM webpage to access your QRUR reports and to self-nominate/register to participate in the VM program.

If you have questions regarding the value based modifier, please contact the Academy at healthpolicy@entnet.org



ICD-10: Help Is Here

While the Academy acknowledges that recent legislation has delayed ICD-10 until October 1, 2015, it is critical that Members continue preparation efforts to meet this deadline. CMS has repeatedly confirmed it will be moving forward with ICD-10. ICD-10 is projected by CMS to provide a multitude of benefits and data that will lead to increased long-term efficiency in the healthcare industry. However, its short-term costs are anticipated to be disruptive, especially for the unprepared. With the ICD-10 transition, use of the new codes will require a significant level of involvement from otolaryngologists themselves and will require many of our members to revamp documentation processes. Physicians will now have to focus on adding further specificity and detail to their documentation. As a result, your Academy

Regardless of your current level of preparedness, it is critical that all physicians focus on the transition.

has been urging you to prepare for the transition over the past year and will continue to encourage members to test their systems for readiness until October 2015

Academy Efforts

ICD-10 is one of the most significant challenges facing physicians today. Noncompliance and lack of preparedness could result in significant financial burdens for practices. Regardless of your current level of preparedness, it is critical that all physicians focus on the impending transition. As with all changes and especially with a change this substantial, the Academy offers members valuable support and services. Some resources the Academy has developed include an ear, nose, and throat (ENT)-specific sample superbill with common ICD-10 codes; a list of the “Top 200” most commonly used ICD-9 codes in an ENT practice and pertinent ICD-10 crosswalks; AAO-HNS/F Coding Workshops focusing on ICD-10 preparedness at various locations across the country by Karen Zupko; and several *Bulletin* articles drafted by various ICD-10 experts. Notably, the Academy has promoted an ICD-10 Miniseminar at the Annual Meeting for the past three years and has made several presentation

materials publicly available on the Academy’s ICD-10 website.


CMS Efforts

CMS has already explored acknowledgement testing during the first week of March and, based on its analysis of the results, will be exploring offering other weeks of acknowledgement testing. Acknowledgement testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. Despite not originally planning on going through full end-to-end testing, CMS has additionally scheduled end-to-end testing for a small sample group of providers during the summer of this year. End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider’s receipt of a Remittance Advice (RA) that explains the adjudication of the claims. Some of the goals of end-to-end testing include:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare Fee-for-Service (FFS) claims systems.
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes).
- Accurate RAs are produced.

To assist with testing efforts, CMS has worked to update some of its National Coverage Determinations by converting relevant ICD-9 codes to their ICD-10 equivalent, found at <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>.

CMS is anticipated to post scheduled testing dates to its website at the end of May, so stay tuned to the Academy e-newsletter and the Health Policy Update for future updates. The Academy continues to work to develop internal resources, repurpose any publicly available ICD-10 resources, and ensure members are well informed about ICD-10. For resources focusing on the ICD-10 transition, visit <http://www.entnet.org/Practice/International-Classification-of-Diseases-ICD.cfm>.

Do you have any recommendations for ICD-10 resources that your Academy should work to develop? Please email healthpolicy@entnet.org. 



The Doctors Company Offers Unique Combination of Benefits to AAO-HNS Members

The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) has partnered with The Doctors Company, an Academy Advantage Premier Partner, to provide Academy members with an exclusive medical malpractice insurance program since 2003. As the nation's largest physician-owned medical malpractice insurer—insuring 1,100 otolaryngologists nationwide—The Doctors Company has insight into the broad range of claims in otolaryngology.

The Doctors Company is fiercely committed to defending, protecting, and rewarding the practice of good medicine. Backed by the financial strength of \$4 billion in assets and a membership of 74,000 physicians, The Doctors Company offers AAO-HNS members a unique combination of coverage features,

aggressive claims defense, and unrivaled protection. Qualified AAO-HNS members receive a program discount of 5 percent and a claims-free credit of up to 25 percent.

AAO-HNS members also have access to industry-leading patient safety tools and programs, including free live and web-based CME, on-site surveys, and informed consent resources. In a recent survey, nine out of 10 members of The Doctors Company said they were satisfied with the company's extensive patient safety resources. Visit www.thedoctors.com/patientsafety to learn more.


The Doctors Company sets the standard for aggressive defense, beginning with the promise never to settle a claim without a member's consent, where permitted by law. This relentless defense also includes Litigation

In a recent survey, nine out of 10 members of The Doctors Company said they were satisfied with the company's extensive patient safety resources.

Education Retreats, which help members facing claims to master defense tactics, and educational videos showcasing actual claims experiences at www.youtube.com/doctorscompany.

The Doctors Company has the national perspective and local expertise to identify emerging trends and protect physicians with innovative coverage solutions. CyberGuard® protects doctors against cyber liability claims, today's fastest-growing threat. MediGuard® provides doctors with legal representation for administrative actions. Both products are offered as part of the company's core medical malpractice policy.

Created in 2007, the Tribute® Plan is a benefit that rewards The Doctors Company's members for their loyalty and their dedication to superior patient care with a significant financial award at retirement. How significant? The highest award to date to an otolaryngologist and AAO-HNS member was \$33,554. Among the more than 1,000 otolaryngologists with Tribute balances, the average balance is currently \$11,850 and the maximum balance is \$60,585. Learn more about this groundbreaking benefit at www.thedoctors.com/tribute.

Join your AAO-HNS colleagues as a member of The Doctors Company—find out how affordable superior medical malpractice coverage for otolaryngologists can be at www.thedoctors.com/quote. 

Thank You for Participating in the 2014 AAO-HNS Socioeconomic Survey

The Health Policy team extends a thank you to members who participated in the 2014 Socioeconomic Survey this past March. Your participation is greatly appreciated, as it is essential for statistically meaningful results. The Socioeconomic Survey has been disseminated every three years through the Academy's Health Policy team since 1997, which allows the Health Policy team to gather information on members' practice patterns, the healthcare environment, and future trends in otolaryngology-head and neck surgery. This data enables the Academy to provide members with useful benchmarking tools. The survey is the most recognized otolaryngology-specific data available and allows the Academy to identify key

issues and policies affecting members, particularly as they relate to practice productivity, revenue, and operations.

The 2014 survey was unique in that it was the first year the Academy incorporated questions regarding alternative payment models, member-recommended electronic health records (EHR) vendors, and important information on relative value units (RVUs) generated annually by practices and individual physicians. Aggregate results will be published in the September *Bulletin*, and will also be on display at the 2014 Annual Meeting in Orlando, Florida, September 21-24. We encourage all members to take the time to view the results and thank you again for your volunteerism!

AAO-HNSF Partners with International Guideline Central for Tools

Recently, the Academy Foundation formed a partnership with International Guideline Central (IGC). IGC is a producer of evidence-based quick reference guides in both paper pocket card and mobile/web application formats for healthcare professionals. AAO-HNSF has joined with IGC to help develop full text clinical guidelines into quick reference tools. The Foundation-endorsed pocket cards and apps serve as quick reference tools that feature highlights of the AAO-HNSF-developed clinical practice guidelines (CPGs).

The IGC relationship will allow AAO-HNSF to 1) Increase the dissemination of its CPGs to a much broader audience and 2) Provide quick

reference tools in both the pocket card and app format to its members. The CPG guideline development group leadership, Foundation staff, and the IGC medical director collectively develop the content to be included in the pocket card and app from the AAO-HNSF guidelines.

The guideline apps and pocket cards feature diagnosis, assessment information, treatment options including their associated levels of evidence, and other recommendations from the AAO-HNSF CPGs. The pocket cards and apps are a tool for providers for point-of-care decision-making and quality improvement.

The app is free to download, with pocket cards and digital applications available to purchase separately. The

mobile app is available for iPhone, iPad, or Android. The mobile app features a dynamic toolbar, which has a word search capability, zoom, bookmark feature, and change font feature. The desktop application features interactive content, intuitive page turn, key word search, full screen and slideshow viewing, high quality zoom, annotation, comments, bookmarks, and individual and multi-user license. To access the app, visit <https://www.guidelinecentral.com/ashp13/> on your mobile device. The website will detect what app is appropriate for you and direct you to download the app. Once you download and register for a free account you will be given a free pocket card in the My Guidelines tab in the app as a sample.

The following guidelines are slated for publication into pocket cards and apps over the coming year: Bell's Palsy, Tympanostomy Tubes, Sudden Hearing Loss, and Tonsillectomy, with additional AAO-HNSF CPGs to follow. **b**

New

AAO-HNSF Guideline Pocketcards

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The first three Otolaryngology Pocketcards Available for Purchase or Download Today!

The **Tonsillectomy in Children**, **Bell's Palsy**, and **Tympanostomy Tubes in Children** **GUIDELINES Pocket Cards** are based on the latest full clinical practice guidelines developed by the American Academy of Otolaryngology–Head and Neck Surgery Foundation.

These practical quick-reference tools produced by Guideline Central contain key points of the condition, detailed recommendations for diagnosis, plus management and treatment recommendation algorithms.

For more information, visit: <http://bit.ly/1h1jDkq> or contact Leslie Caspersen, lcaspersen@entnet.org or phone: 703-535-3748

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The Candidates for President-Elect Outlined Their Platforms: An Early Look

During the February/March AAO-HNS/F Leadership Forum, The BOG hosted its yearly event for candidates for president-elect to introduce themselves and lay the groundwork for their official platforms and statements to the membership.

This year's candidates, **Sujana S. Chandrasekhar, MD**, and **J. Pablo Stolovitzky, MD**, readily engaged the audience displaying their mutual strengths of loyalty, zest for a challenge, and specialty pride.

According to the Bylaws, in advance of the presentation, the Nominating Committee selects three questions that the candidates address both live during this forum and also more formally in their official statements that are fully published in the June *Bulletin*. By coin toss, Dr. Stolovitzky began the exchange.



Sujana S. Chandrasekhar, MD



J. Pablo Stolovitzky, MD

This year, Drs. Chandrasekhar and Stolovitzky responded to one question from the audience as well. It was presented by the Immediate Past BOG Chair **Denis Lafreniere, MD**: **"How would you expand the reach of the Academy while improving non-dues revenue?"**

To see the full perspective of these Members, read the full transcript and audience response online at <http://aaobulletin-365.ascendeventmedia.com>.

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Each title contains: 1) Description of the ailment
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Abbreviations, Acronyms, and Committees You Need to Know to Be an Effective Advocate for the Specialty

Capitol Hill Powerhouses

- **HELP**—U.S. Senate Committee on Health, Education, Labor, and Pensions. The committee has jurisdiction over multiple legislative issues, including some healthcare proposals.
- **E&C**—U.S. House Committee on Energy and Commerce. The committee has principal jurisdiction over healthcare issues and related agencies, including the Department of Health and Human Services and the Centers for Medicare & Medicaid Services.
- **Finance**—U.S. Senate Committee on Finance. The committee has principal jurisdiction over matters relating to taxation and funding for programs such as Medicare and Medicaid.
- **W&M**—U.S. House Committee on Ways and Means. The committee is the chief tax-writing committee in the U.S. House of Representatives, with jurisdiction over all taxation, tariffs, Social Security, unemployment benefits, Medicare, and welfare programs.

Coalition Concoction

- **CHHC**—Congressional Hearing Health Caucus. CHHC is a bipartisan caucus of members from the U.S. House and Senate committed to supporting the needs of people with hearing loss and other auditory disorders. The AAO-HNS is a member of the Friends of the CHHC.
- **DHHA**—Deaf and Hard of Hearing Alliance. DHHA is a coalition that seeks changes to federal public policy to help improve the quality of life for people who are deaf, hard of hearing, or have hearing loss. The AAO-HNS is a member of DHHA.
- **HCLA**—Health Coalition on Liability and Access. HCLA is a national advocacy coalition working to advance medical liability reform at the federal level. The AAO-HNS serves on the HCLA Board.
- **PARTNERS**—Tobacco control coalition led by the Campaign for Tobacco-Free Kids. The AAO-HNS is a member of this coalition effort.

Who's Who in Government

- **CBO**—Congressional Budget Office. CBO produces independent analyses of budgetary and economic issues to support the Congressional budget process. CBO “scores” proposed bills to help lawmakers understand the cost or savings associated with a legislative proposal.
- **CMS**—Centers for Medicare & Medicaid Services. CMS is a federal agency within the U.S. Department of Health and Human Services. It is responsible for administering the Medicare program and working with states on administering their Medicaid programs.
- **MedPAC**—Medicare Payment Advisory Commission. MedPAC is an independent federal body established by the Balanced Budget Act of 1997. It is responsible for advising Congress on topics within the Medicare program, and, more specifically, on issues dealing with payments to private health plans participating in Medicare and health providers that serve Medicare beneficiaries.



Other Alphabet Soup

- **ACA**—Affordable Care Act. ACA is the healthcare reform law established in 2010. Some refer to the law as Obamacare.
- **CR**—Continuing Resolution. A resolution made by Congress to continue funding for a program if the fiscal year ends without a new appropriation in place.
- **HIT**—Health Information Technology. Software and computer systems to make medical records electronic, reducing paperwork, and redundant forms. Federal and state governments are implementing policies to encourage the adoption of HIT while promoting quality initiatives and protecting patient privacy.
- **IPAB**—Independent Payment Advisory Board. The IPAB is an unelected government body established under the ACA. It is charged with the responsibility for reducing the rate of growth in Medicare without affecting coverage or quality. The Board is scheduled to implement its first proposal in 2015 (likely to be delayed). The AAO-HNS supports *repeal* of the IPAB.
- **MIPS**—Merit-Based Incentive Payment System. A concept included in the bipartisan, bicameral SGR repeal legislation (H.R. 4015/S. 2000). Beginning in 2018, the MIPS would establish a streamlined and improved incentive payment program that would focus the fee-for-service system on providing value and quality. The program would consolidate the three existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health record (EHR) use with which professionals are familiar, but in a cohesive program that avoids redundancies.
- **MLR**—Medical Liability Reform. MLR is a critical healthcare reform issue in the U.S. and a legislative priority for the AAO-HNS. Proponents of MLR are working to implement or amend legislation to reduce or cap excessive liability insurance costs for physicians while

ensuring fair compensation for patients injured by negligent actions.

- **PAC**—Political Action Committee. PACs allow individuals with shared interests the opportunity to pool their voluntary donations to make contributions to federal candidates on behalf of the entire group. PACs represent a legal and ethical way to participate in the election process. ENT PAC (www.entpac.org) is the political action committee of the AAO-HNS.
- **SGR**—Sustainable Growth Rate. The SGR formula is a flawed expenditure target against which healthcare costs are compared. Generally, if annual healthcare costs fall below the target, Medicare reimbursement rates are increased. Conversely, if annual healthcare costs exceed the target, Medicare payment rates are

decreased in order to reduce costs. Since healthcare costs tend to grow faster than the rate of inflation, the flawed formula has historically triggered annual Medicare physician payment cuts, which have typically been averted by Congressional action. The AAO-HNS supports H.R. 4015/S. 2000, legislation to repeal the SGR.

- **TIA**—Truth in Advertising. The AAO-HNS and others in the physician community support state and federal efforts to implement TIA legislation requiring *all* healthcare providers to inform patients of their credentials and/or level of training in patient communications and marketing materials. Truth in advertising is an important component of providing patients with the best possible care. [b](#)






Hot Dogs, Hamburgers, and Politics

The summer months are near, which means lots of picnics, parades, and local gatherings. Members of Congress are notorious for making “appearances” at such events. Don’t let them just walk in parades and eat hot dogs at the county fair. Take

advantage of this great opportunity to meet your elected officials and raise the visibility of key legislative issues affecting your patients and the specialty. Unable to attend these public events? Consider scheduling a private meeting with your lawmakers

at their Congressional district office. Or better yet, invite them to visit your medical practice. The next scheduled Congressional “work period” is May 10-18. Email govtaffairs@entnet.org today to learn more about the In-district Grassroots Outreach (I-GO) program and to request help in scheduling your meetings! 

*** | www.entnet.org/advocacy

What is the I-GO Program?

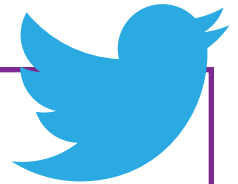
Join your colleagues and participate in the Academy’s **In-district Grassroots Outreach (I-GO) program!** The **I-GO program** is the best way to meet with your legislators locally to advocate on behalf of the specialty and your patients. Just pick a setting that works for you:

- Host a member of Congress at your hospital or practice;
- Meet in-person with a legislator at his/her local district office;
- Attend a local fundraiser (or better yet, host one); or
- Participate in a town hall or district conference call.

In addition to assistance with scheduling the meeting, the AAO-HNS Government Affairs team will provide you with talking points, a legislative background on your representative, and a Q&A session with Academy staff before the meeting. To participate or find out more, contact the Government Affairs team at govtaffairs@entnet.org.



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On the Frontlines: State Legislative Tracking

A number of 2014 state legislative sessions are still in high gear. AAO-HNS members are a key resource for tracking state legislation and communicating to policymakers its influence on the specialty, physician practices, and patients. Join the growing team of AAO-HNS state trackers by emailing govtaffairs@entnet.org to receive daily or weekly legislative tracking updates. If you identify legislation needing Academy action (e.g., letter, action alert, testimony), simply fill out the online State Action form at www.entnet.org/Advocacy or contact us at the above email address regarding the legislative proposal.


Stay Informed: Follow Government Affairs on Twitter

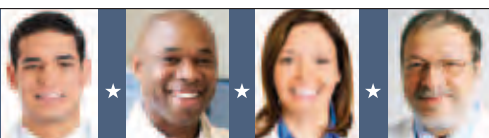
Do you want to be one of the first to know the status of healthcare bills moving through Congress? Follow the Government Affairs Twitter account @AAOHNSGovtAffrs. By following us, you can learn more about the issues affecting the specialty, your practice, and your patients, including repeal of the flawed Sustainable Growth Rate (SGR)

formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Not a fan of Twitter? You can also check the Government Affairs webpage for regular updates at www.entnet.org/Advocacy.



2014 is an election year for Congress. ENT PAC, the political action committee of the AAO-HNS, financially supports federal congressional candidates and incumbents who help and/or advance the issues important to otolaryngology—head and neck surgery. ENT PAC is a NON-PARTISAN, ISSUE-DRIVEN entity that serves as your collective voice on Capitol Hill to increase the visibility of the specialty with key policymakers. To learn more about ENT PAC, visit our PAC website at www.entpac.org (log-in with your AAO-HNS ID and password).





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- Email alerts on legislative issues impacting our specialty; and
- Advocacy **Calls to Action** with easy instructions on contacting your legislators.

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Coding Update: New CMS G-Code/Modifier Requirements for Therapy Services

Michael Setzen, MD
Immediate-Past Coordinator for Practice Affairs;
Manderly Cohen, MS CCC-SLP, and Jenna Minton, Esq., Senior Manager of Health Policy

For CY 2013, CMS finalized several key changes to reporting requirements associated with the provision of therapy services, and beginning on January 1, 2013, it implemented a claims-based data collection strategy to collect data on patient function. This policy encompassed a wide array of therapy services, including the Medicare Part B outpatient therapy benefit, therapy services under the Comprehensive Outpatient Rehabilitation Facility (CORF) benefit, and “incident to” services furnished by physicians or nonphysician practitioners, and included services furnished in hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), CORFs, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and private offices.

CMS defines the term “therapists” as all practitioners who furnish outpatient therapy services, including physical therapists, occupational therapists, and speech-language pathologists in private practice and those therapists who furnish services in the institutional settings, physicians, and nonphysician practitioners (including physician assistants, nurse practitioners, and clinical nurse specialists, as applicable). ***Under this policy, claims for therapy services must now include non-payable G-codes and modifiers, which will allow the agency to capture data on the beneficiary’s functional limitations at various points during the provision of therapy. For therapy services being furnished that are not intended to treat a functional limitation, the therapist should use the G-code for “other” and the modifier representing zero.***

A specific example of how this would apply in otolaryngology is when performing

FEES/FEESST or providing therapy, including speech-language evaluation and treatment services for Medicare Part B beneficiaries, providers must report outcomes on claim forms. To facilitate this reporting, CMS established non-payable G-codes for reporting on claims for Medicare Part B beneficiaries receiving therapy services. Each non-payable G-code listed on the claim form must be accompanied with a severity/complexity modifier. The modifier represents the functional impairment on a 7-point severity/complexity scale.

G Codes

When billing FEES/FEESST CPT codes, specifically 92610 *Evaluation of oral and pharyngeal swallowing function*, 92612 *Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording*, and 92616 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording*, where only an evaluation was performed and the patient will not be seen for therapy at the same facility, all three swallowing G-codes must be used when billing for the evaluation (G8996,

G-Codes Functional Limitation & Status	
Swallowing	
G8996	Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G8997	Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy.
G8998	Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation.

G8997, and G8998) in addition to the appropriate severity modifier for each code. See below.

Click here for a full list of available G-codes for reporting therapy services.

Severity Modifiers

Note: Corresponding National Outcomes Measurement System (NOMS) *Functional Communication Measures* [PDF] levels are listed here. Use of NOMS can assist with G-code and severity modifier selection, but is not required by CMS. [b](#)

Modifier	Impairment Limitation Restriction	FCM Level
CH	0 percent impaired, limited or restricted	7
CI	At least 1 percent but less than 20 percent impaired, limited or restricted	6
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted	5
CK	At least 40 percent but less than 60 percent impaired, limited or restricted	4
CL	At least 60 percent but less than 80 percent impaired, limited or restricted	3
CM	At least 80 percent but less than 100 percent impaired, limited or restricted	2
CN	100 percent impaired, limited or restricted	1

Members seeking additional information can access a full summary of this issue at <http://www.entnet.org/Practice/CMS-News.cfm>. [b](#)

Accessing Big Data for Research?

A New Resource for AAO-HNS Members

Secondary data analysis can be an efficient research tool for identifying large numbers of cases for study without the time needed to collect primary data. For these reasons, there is increasing interest in secondary data analysis within the field of otolaryngology.

The AAO-HNSF Outcomes Research and Evidence-based Medicine (OREBM) Committee is pleased to announce that there is a new resource available to members on the AAO-HNS/F website. If you are conducting or looking to conduct research and are interested in using large datasets, there are many options available. But how do you decide which one is best for your purposes and your budget?

Under the guidance of **Jennifer J. Shin, MD, SM**, and **Melissa A Pynnonen, MD**, committee members and volunteers provide a list of existing datasets that may be appropriate for otolaryngology research. Each dataset is unique, with its own advantages, disadvantages, and nuances. To help newcomers identify a dataset that may be relevant for a particular research question, a basic overview of

each dataset, example publications, and links for obtaining further information are provided. Some of the information presented includes: patient ages; practice setting, date range available; examples of publications; information about access; cost estimate(s); contact/website information; ease of use; and some pros/cons to using the data set for analysis. Datasets for inclusion were selected based on recommendations from members of the OREBM Committee.

Databases included on the site:

- Kids' Inpatient Database (KID)
- MarketScan® Commercial Claims and Encounters and Medicare Supplemental and Coordination of Benefits
- MarketScan® Health and Productivity Management/MarketScan® Health Risk Assessment
- The National Ambulatory Medical Care Survey (NAMCS)
- National Cancer Database (NCDB)
- National Hospital Ambulatory Medical Care Survey (NHAMCS)
- Nationwide Emergency Department Sample (NEDS)

Outcome Instruments


Did you know that the OREBM Committee also developed a web resource that presents key outcome instruments in otolaryngology-head and neck surgery? The site can assist the clinician looking to learn more about these tools and implement them in their practice or educate the more seasoned researcher who wants to stay up-to-date on the key tools and supporting literature. Learn more at <http://www.entnet.org/EducationAndResearch/outcomesTools.cfm>.

- Nationwide Inpatient Sample (NIS)
- SEER-Medicare
- State Ambulatory Surgery Databases (SASD)
- State Inpatient Databases (SID)
- Surveillance, Epidemiology and End Results (SEER)

This list is not meant to be exhaustive, but rather a primer and foundation for members interested in beginning secondary data analysis in otolaryngology. The list will be reviewed periodically and updated as appropriate.

Special thanks to **Emily F. Boss, MD, MPH**; **Amy Y. Chen, MD, MPH**; **Seth M. Cohen, MD, MPH**; **Dane J. Genther, MD**; **Eric J. Kezirian, MD, MPH**; **Frank R. Lin, MD**; **Gordon Sun, MD**; and **Bryan K. Ward, MD**, for sharing their knowledge of these databases and assisting with this project.

We hope members find this to be a valuable resource and that it will help to facilitate new studies within the field of otolaryngology. To access the site, visit <http://www.entnet.org/EducationAndResearch/Research-Databases.cfm>.

If you have suggestions for additional databases or outcome instruments to be included on these sites or supplemental information that may be helpful, please let us know. Email Stephanie L. Jones, director of Research & Quality Improvement, at sljones@entnet.org. 



Is PSQI Vulnerable?

Rahul K. Shah, MD
George Washington University School of Medicine
Children's National Medical Center,
Washington, DC

Of course this is a rhetorical question—the modern patient safety and quality improvement, following the clarion call from the Institute of Medicine, is based on robust data, methodology, and outcomes. As such, it was an absolute surprise to many involved in PSQI (Patient Safety and Quality Improvement) research and initiatives that there was fraud and deceit amongst us.

I will try to summarize what is reported in the lay press about Dr. Charles Denham, MD, who at the time of a Justice Department settlement co-chaired a prominent committee, the NQF Safe Practices

Committee, at the National Quality Forum. Please research this yourself to obtain the most accurate information.

As members may recall, the Academy has physician and staff representation at the major quality organizations and associations, including (but not limited to) the Ambulatory Quality Alliance (AQA), National Quality Forum (NQF), AMA's Physician Consortium for Performance Improvement (PCPI), and the Surgical Quality Alliance (SQA). It is a prescient decision for the Academy to be participating and involved in these organizations for more than a half-decade as we are well represented in the national landscape and able to adjust to changing influence. For example, if we were to plot the influence of these societies during the past many years, we would see evolving influence based on national priorities.

Hence, the allegations of fraud of Dr. Denham hit close to home for our membership, as we are participants in the NQF.

The government alleges, while Dr. Denham co-chaired the NQF Safe Practices Committee, that a company he owned was provided contracts by CareFusion to promote its product, ChloroPrep. The product is used for surgical antisepsis, however the company was promoting its use off-label, which is not allowed. The allegation from the Justice Department was that the committee that Dr. Denham co-chaired was subjected to his influence and that he personally profited from payments from CareFusion. CareFusion was fined \$40 million by the Justice Department. The story and the accompanying blog posts Wachter's World are

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CPT for ENTs



In response to commonly asked coding questions, the Health Policy team, in collaboration with the Academy CPT team, has developed **coding guidance articles**, better known as **CPT for ENTs**.

These articles address common coding questions, outline common ENT coding scenarios, and clarify coding changes for services frequently reported by our specialty.

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For a full list of the offered articles, please visit:
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For questions, please email the Health Policy team at
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worth reading; indeed my co-chair of the AAO-HNS/F PSQI committee, **David Roberson, MD**, even opined on the post! My point being that this downfall, the first of such impact in the PSQI movement, has brought out many of our most respected safety experts to voice their sentiments.

I do not personally know Dr. Denham, but have heard him speak a few times. He is a gifted messenger and certainly a patient advocate. Nevertheless, the point of the column this month is to demonstrate that even a field as purely motivated as patient safety and quality improvement is susceptible to fraudulent behavior.

We must remain vigilant as Academy members and ensure that just because a group with good motives that is led by experts presents a claim or action does not a priori and without evidence make that claim substantiated. Academy member and journal editor, **Richard M. Rosenfeld, MD, MPH**, has done a tremendous job of asking the difficult questions about statistics, correlations, and causations when I have seen him at scientific meetings. This level of scrutiny is what we as individual Academy members can do with regards to statements from quality and safety organizations. We must not simply rollover and accept these mandates—the onus is on us as practicing providers to see the data and understand the rationale for such measures. I have seen our membership in action and am confident that we always do push for the data and transparency.

In summary, the modern patient safety and quality improvement movement since the 2000s is not a fraud—the data is robust, medicine is embracing proven quality and scientific methodologies, and the outcomes of actual lives saved is exciting. However—*caveat emptor*: If a product sounds too good to be true, if an initiative has results that are not rational, and if someone seems conflicted—then double-check, as you may be right! If you can spare some time, these articles outlined below reinforce the absolute need for every organization engaging in these types of activities to have solid disclosure policies addressing of conflicts of interest. 



References

1. <http://online.wsj.com/article/BT-CO-20140109-709237.html>, accessed March 9, 2014.
2. <http://community.the-hospitalist.org/2014/01/30/patient-safety-first-scandal-the-sad-case-of-chuck-denham-carefusion-and-the-nqf/>, accessed March 9, 2014.
3. <http://www.forbes.com/sites/michaelml-lenson/2014/02/14/the-money-the-md-and-a-12-million-patient-safety-scandal/>, accessed March 3, 2014.

Editor's Note:

Please read Dr. Denham's statement that can be found within the Wachter's World article (<http://community.the-hospitalist.org/2014/01/30/>). Specifically it appears in the commentaries from a February 22, 2014, 7:41pm reader.

We encourage members to write us with any topic of interest and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at

qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.



Chicago Temporal Bone Course

A small-group, hands-on workshop directed by Richard J. Wiet, M.D. This course will review the surgical and medical treatment options for common ear and hearing disorders. One temporal bone will be provided to each participant for surgical dissection.

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The registration fee includes course materials, daily continental breakfast, refreshment breaks, and lunch. For more information, contact Susan Marshall at 708-245-8050 or Susan.Marshall@ahss.org.



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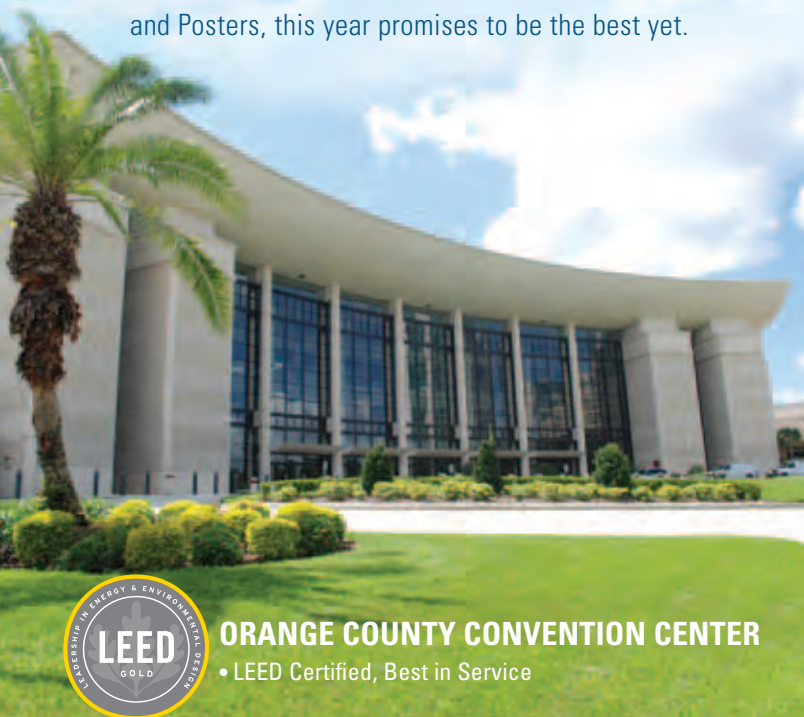
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Out of Committee: The Cochlear Implant: Past, Present, and Future of a Game-Changing Device

From the Drugs and Devices Committees

The development and use of the cochlear implant has been one of the most significant advances in otolaryngology in the last century. It has truly revolutionized what we as otolaryngologists can offer to our patients with the most significant cases of hearing loss. While this “game-changing” medical device now stands in the limelight, its conception and early development was met with much resistance from recognized leaders in our field and great opposition from the deaf community, which considered it “genocide” to their culture.

The early work of Volta, Djourno, Eyries, and others eventually led William House to successfully implant a single electrode device into the cochlea of a human patient in 1961. Shortly thereafter, Blair Simmons and Robin Michelson placed multichannel implants. Subsequently, decades of dedication by surgeons, scientists, audiologists, and speech pathologists have enabled countless deaf children and adults to hear. Current implants allow recipients to gain sufficient open set speech to talk on a telephone, be mainstreamed to enter schools with hearing children, and use speech to function and communicate well in various professional and social settings. Studies have shown that many implant users perform at or near the level of normally hearing peers on certain speech testing batteries. The magnitude of these achievements is reflected in the awarding of the prestigious Lasker-DeBakey Clinical Medical Research Award to Graeme Clark, Ingeborg Hochmair, and Blake Wilson in 2013 for their efforts in the development of cochlear implants.

Despite these successes and numerous studies that have shown that cochlear implants are both clinically and cost effective, the overall utilization rate of this device in the United States is estimated at an astoundingly low 6 percent. Specifically for children in the U.S., the utilization rate is


a much more favorable 50 percent of those who would qualify based on their audiological profile, largely due to the positive effects of the implementation of Universal Newborn Hearing Screening in 1999. Nevertheless, this still fails to compare to the 90 percent utilization rates in certain areas in Europe.

Several factors may be contributing to this low utilization rate. The first is that there is a low general awareness of cochlear implants and their potential benefits by both the public as well as primary care physicians. This poor understanding of candidacy and outcomes by referring providers may be a critical hurdle in getting the majority of patients who could benefit from an implant into the office of an otolaryngologist who can offer services. In addition, while there have been some positive changes from the early days of cochlear implantation, political resistance from organizations such as the deaf community, National Association of the Deaf, and the Autism Free America groups continue to exist.

Lastly, financial issues limiting hospitals and clinics continue to play a major role. With the metric of “quality of care” being on the forefront of healthcare governing bodies, hospital administrators, and the public, the development of widely accepted “best clinical practice” guidelines may provide a means to improve our ability to reach a greater proportion of the patients who could benefit from a cochlear implant. With the focused efforts of groups such as the recently incorporated American Cochlear Implant Alliance, we stand stronger to make progress on this front.

Despite these challenges, the number of patients receiving cochlear implants continues to grow and indications for surgery are further expanding. Initially a therapy offered only to adults with bilateral profound hearing loss, later it was approved for children two years and older in 1990 by the

FDA. Today, children 12 months, and even younger in some cases, are gaining hearing with surgery. In addition to the lower limits of age, the increasing benefits of surgery outweighing the risks have permitted the audiological criteria for candidacy to evolve allowing for patients with less severe levels of hearing loss to qualify for implantation. While the standard adult candidate is someone who is considered to have little or no benefit from hearing aids based on speech recognition testing with scores of less than 50 percent on the ear to be implanted and less than 60 percent in the non-implanted ear or in the binaural condition, there has been much research demonstrating the benefits of cochlear implantation in patients with residual low frequency hearing. Hearing preservation techniques and hybrid implants providing electrical and acoustic stimulation have been used for years in Europe. These devices are currently in the final stages of approval by the Food and Drug Administration. This would provide individuals in the United States with high frequency sensorineural or “ski slope” hearing loss the opportunity to improve their communication function with a cochlear implant. In addition, currently there is much investigation in the areas of cochlear implantation for single-sided deafness and a therapy for tinnitus that may soon further expand the use of this innovative medical device.

Future technologies are aimed at enhancing sound quality, improving safety and reliability, and reducing costs. Incorporating technologies such as drug-eluting electrode arrays to reduce trauma from surgery, repairing damaged tissue biologically with stem cells, and developing new, more effective materials may provide avenues to bring the function of cochlear implants to the next level. With these ongoing efforts, we likely do not yet know the limits yet of this game-changing device. 

AAO-HNS Members May be Eligible for FACE

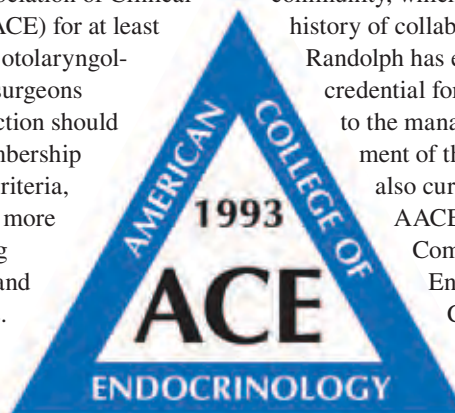
AAO-HNS Member **Gregory W. Randolph, MD, FACE**, who has worked closely with the AACE for many years presenting at their meetings and serving in leadership positions, has been dedicated to establishing otolaryngologist—head and neck surgeon eligibility for the FACE designation. He and fellow Academy supporters named here are pleased to extend the following information to you in concert with ACE and AACE colleagues.

The Fellow of the American College of Endocrinology (FACE) designation is achievable by otolaryngologist-head and neck surgeons who provide a high standard of excellence, achievement, and quality of patient care given to their patients with endocrine disorders.

Physicians eligible to receive this honor must be members in good standing

of the American Association of Clinical Endocrinologists (AACE) for at least three years. As such, otolaryngologist-head and neck surgeons seeking FACE distinction should apply for AACE membership if they meet certain criteria, such as 50 percent or more of their practice being dedicated to thyroid and parathyroid disorders. FACE recipients are honored with induction into the College at the ACE Convocation, which takes place during the AACE Annual Meeting. Fellows can then use the FACE post-nominal title to denote the honor.

AACE is eager to engage the otolaryngologist-head and neck surgeon



community, which already has a great history of collaboration. In fact, Dr. Randolph has earned the FACE credential for his contribution to the management and treatment of thyroid cancer. He is also currently chair of the AACE Endocrine Surgery Committee and AHNS Endocrine Surgery Committee and a former AAO-HNSF International Coordinator and Endocrine Surgery

Committee Chair. With this experience, he will welcome your interest. He has found that many AACE members focus on diseases of the thyroid and parathyroid glands and work well in partnership with head and neck surgeons. [b](#)



AACE and ACE

- Jeffrey I. Mechanick, MD, FACP, FACE, FACN, ECNU; president, AACE
- Daniel Einhorn, MD, FACP, FACE; President, ACE
- R. Mack Harrell, MD, FACP, FACE, ECNU; president-elect, AACE
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Thyroglossal Duct Cysts, Elephantitis, and More: The Different Sides of Walter E. Sistrunk

Amit A. Patel, MD
Otolaryngology History Society (OHS)

Treatment of the thyroglossal duct cyst was revolutionized by **Walter Ellis Sistrunk, MD**, of the Mayo Clinic in 1920 and the development of the procedure that now bears his name.

Since that time, the procedure has remained, for the most part, unchanged and is the gold standard for treatment of thyroglossal duct cysts. Dr. Sistrunk was also a consummate general surgeon, who made contributions not only to thyroid surgery, but also to fields as diverse as oncologic breast surgery and vascular surgery.

Born in Tallahassee, AL, in 1880, Dr. Sistrunk received a degree in pharmacy from the Alabama Polytechnic Institute in 1900. From there, he attended Tulane Medical College, graduating in 1906. He began his career in private surgical practice in New Orleans and Lake Charles, LA.

He moved to the Mayo Clinic in 1911 as an assistant in the department of pathology. There he published a landmark paper on intestinal parasites

in which he demonstrated that the incidence of amebiasis was more widespread in the United States than had previously been thought. This paper was cited for more than two decades as a preeminent paper on parasitology.

In 1912, from the Mayo Clinic's department of parasitology, Dr. Sistrunk moved to its department of surgery and in 1918 he was appointed as assistant professor. In 1921, he published his most famous work on the surgical treatment of cysts of the thyroglossal duct tract.

He discovered the key to avoiding recurrence was removal of the entire epithelial-lined tract extending to the base of the tongue. The procedure is so efficacious that it has remained essentially unchanged in the last century and rightly bears his name.

Dr. Sistrunk also made significant advances in the surgical treatment of chronic lymphedema or elephantiasis. He modified an earlier operation known as the Kondoleon operation, in which large swaths of tissue are removed from the edematous limb to provide relief from symptoms. While this procedure is rarely performed today, contemporary physicians noted Dr. Sistrunk's contribution to the point where some literature refers to the Kondoleon operation as the Sistrunk operation.

Dr. Sistrunk continued his work and research at the Mayo Clinic until 1929, when he moved to Baylor University, returning to his native South after his son died in an accident.



Walter W. Sistrunk, MD (1880-1933).

His rich contributions to the fields of surgery and medicine cannot be underestimated.

In a larger sense, however, it is important to remember that physicians should not be pigeonholed into their medical eponyms. For example, Theodor Billroth is remembered for his surgical treatment of peptic ulcer disease, but, lest we forget, he performed the first total laryngectomy. Similarly, George W. Crile is known for his contributions to neck dissections, but we should also remember that he performed the first successful blood transfusion.

We should not do away with eponyms altogether, however, as doing so would dismayingly cause us to lose a sense of connection with the history of our field. [b](#)

Interested in Our History?

- Join or renew your membership in the Otolaryngology Historical Society (OHS). Check the box on your Academy dues renewal or email museum@entnet.org.
- Save the date—the OHS annual meeting and reception will take place from 6:30 pm-8:30 pm September 22 in Orlando, FL.
- Present a paper at the OHS meeting—email museum@entnet.org. The deadline is May 15.

Otolaryngology in Kenya

Robert T. Standring, MD
*Resident, Henry Ford Health System
 Humanitarian Travel Grant Awardee
 (September 13–23, 2013)*

It was 4:30 am on a crisp morning in a rural town of Kenya called Migori. The sun was starting to make its way out to paint the beautiful tropical landscape. I was riding in a 30-year-old pickup-truck-turned-ambulance, rushing a patient from our makeshift surgery center to one of the local hospitals. **Tamer Ghanem, MD**, and I had just finished taking this post-op thyroid patient back to the operating room in the middle of the night to evaluate for a tracheal tear. She had undergone a hemi-thyroidectomy for a large substernal goiter the previous night and in our post-operative recovery room

started to desaturate, had neck crepitus, and her drain would not hold suction. We suspected tracheal tear versus a pneumothorax and immediately took her back to the OR for exploration. During the surgery, we worked quickly and efficiently, but were slowed by multiple power outages and numerous massive flying bugs that “dive-bombed” our surgical field. We found no tracheal tear and later confirmed our other suspected diagnosis of a pneumothorax from a chest X-ray at the local hospital.

Riding in the ambulance with the early-morning African air cooling my sweat-soaked scrubs, I had 20 minutes to reflect on what a whirlwind the past three days had been. After 80 surgeries and 690 patient visits in this small African village, my worldview and idea of medicine was forever changed.

Kenya Relief is a faith-based, non-profit organization that sends 16 surgical and religious teams from around the United States to Migori to offer medical and surgical services. Our group consisted of seven surgeons, two primary care physicians, and an audiologist. Six CRNAs, six nurses and scrub techs, one pharmacist, one non-medical personnel, and a journalist accompanied us on our trip. The surgeons included three ENT attendings from Henry Ford Health System with subspecialization in facial plastics, head and neck, and neurotology. There was a pediatric general surgeon and a general surgeon as well as two ENT residents. This team from Henry Ford Health System was the largest and most specialized group to ever travel to the Kenya Relief campus in Migori. **Syed Ahsan, MD, Tamer Ghanem, MD, and Lamont R. Jones, MD**, supervised us.

The 80 patients who underwent surgery consisted of 28 thyroidectomies, 10 otologic surgeries, seven midface/cleft palate/mandible procedures, six superficial face/scalp lesions, and 29 general

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surgery cases. The otologic surgeries were the first that had been performed at Kenya Relief. There were two cases that required patient hospitalization post-operatively.

After flying to Nairobi, we took a six-hour van ride to Migori. During our first day we toured the campus and spent time with the orphans. They put on an amazing native dance performance for us. We then surveyed the clinic that we made into our surgery center and set up all of our trays and equipment. The night prior to the first operating day, physicians met with patients waiting at the clinic to begin triaging patients based on severity of health problems and surgical complexities. Full histories and physicals were performed, written informed consent was obtained on all patients requiring surgery, and the site of surgery was marked during the initial evaluation. Two family medicine physicians and the surgeons performed the pre-screening process. All thyroid patients were placed in order of severity of clinical symptoms and size. Otology patients were placed in a separate clinic to be assessed by the neurotologist and an audiologist for evaluation and hearing exam.

The amount we were able to accomplish and the difference we made in such a little amount of time was astounding. Yet, despite the fact we saw so many people and changed so many lives, there were huge groups of people that we had to turn away due to a lack of time and supplies. We brought more than 30 crates of supplies and operated until we ran out and could no longer perform surgeries. We would have wanted to perform total thyroidectomies on patients, but chose to do only hemi-thyroidectomies due to the lack of access to thyroid hormone replacement. In the future, it would be beneficial to bring a large supply with us to distribute to the Kenyans. The team plans to return every year with residents and staff, keeping continuity of care for the patients and surrounding communities. This mission trip was a once-in-a-lifetime experience that has positively changed my view on the world and how I practice medicine.

I would like to thank the AAO-HNSF Humanitarian Efforts Committee for helping me participate in this experience. 



Kenya Relief group. Dr. Standing is fourth from the left in the back row.



Women with goiters line up prior to surgery.



Patients wait outside the surgery center to be evaluated.

Faces of Tomorrow Aids Ecuador

Reflection on a Medical Mission to Ecuador

Dhava Setabutr, MD
Chief Resident
Penn State Hershey Medical Center
Otolaryngology–Head and Neck Surgery

Humanitarian Travel Grant Awardee

“**T**hey’re saying that they would like for you to be their baby’s godfather,” replied Mary Camille when I asked what the parents were saying at our discharge clinic. I asked again to make sure I understood what they had said. I was flattered and completely overwhelmed. I didn’t know how to respond. That single instant defined my mission trip to Ecuador and signified the influence our group had made on not only individual patients, but also families and entire communities.

Since 2007, Faces of Tomorrow (FOT) led by **Brian K. Rubinstein, MD**, has performed countless cleft lip and palate repairs, provided prenatal counseling, postoperative speech therapy, and support for patients and families alike afflicted with these facial deformities.

This past June, Dr. Rubinstein and his surgical team including **Charles W. Shih, MD**, of Kaiser Permanente Oakland, **Nima Pahlavan, MD**, of Kaiser Permanente Sacramento, **Travis T. Tollefson, MD**, of UC Davis-Sacramento and resident duo of **Ethan Handler, MD**, of Kaiser Permanente and me worked alongside a cohesive team of anesthesiologists, pediatricians, speech therapists, surgical technicians, a dentist, nurses, and Peace Corps volunteers



A cleft lip doesn’t stop this child’s brightness from shining through.

in Quito, Ecuador, to provide care for the underserved population of children in the region who may not receive adequate treatment for their cleft lip or cleft palate. Setting up shop at Tierra Nueva Hospital with the assistance of local physician Patricia Jarren, our team saw and evaluated more than 70 patients and performed more than 50 surgeries. Operations included cleft lip and palate primary

repairs and revisions, rhinoplasties, and palatoplasties after formal speech evaluations by our bilingual speech team. From Monday through Friday, we ran three operating tables, two of which resided in the same operating room. From the administrative check-in to the PACU setting and morning rounds, volunteers from Montana, New York, and Texas arduously facilitated each step in these children’s transformation. Much of the bureaucracy and wastefulness we see at many high-end medical centers in the United States was non-existent and replaced by basic healthcare supported only by the generosity of the human spirit.

The reflection that still moves me was walking into the waiting room at 8:00 am on Saturday of our discharge clinic and seeing these families waiting for our arrival. They were so grateful and overjoyed with the outcomes of their surgery, each wanting a photo opportunity with any of us who had helped them along the way.



(L) Dr. Handler poses with a patient and mother in pre-op alongside Dr. Setabutr.

We owe a debt of gratitude to the people of Ecuador who opened their hearts to us as co-workers, surgeons, nurses, and friends. They entrusted their lives and the lives of their children to a group of strangers who merely wanted to offer what we have been taught. I urge all residents to consider reaching beyond their comfort zone of Instagram accounts, flat screens, case logs, and publications to reach out to a community, local or abroad, that might benefit from what you've learned in your five years of residency as an otolaryngologist, I guarantee you won't regret it. I know I won't.

This trip will serve as additional groundwork for return trips to people in need through Faces of Tomorrow and I only hope I will be granted the opportunity to return one day. I would like to thank the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation for their support of my travel to this mission.

For further information on the mission and ways to help, please visit www.facesoftomorrow.org.

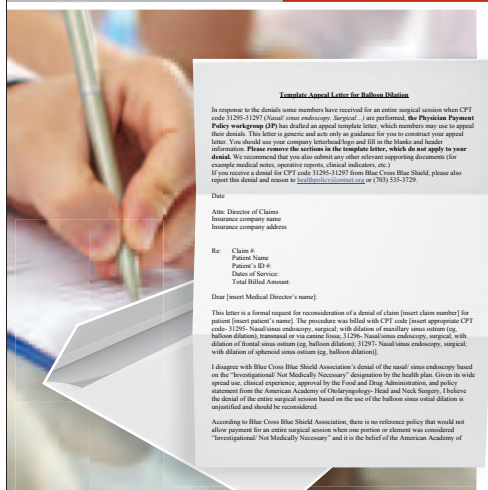


Dr. Rubinstein consults his colleague on their previous day's surgery during morning rounds.

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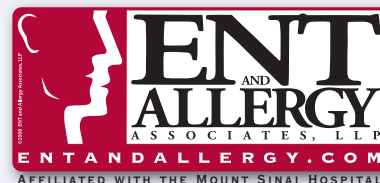
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is offered by the Michigan Ear Institute
in conjunction with Providence Hospital,
Southfield, Michigan and Wayne State University. Two
positions are available commencing July 1, 2015
for a period of two years

A strong otology residency training experience is required.
The candidate must be board eligible or certified and
be able to obtain a license to practice medicine in the State
Of Michigan.

Contact:

Michael J. LaRouere, MD
Fellowship Program Director
Michigan Ear Institute
30055 Northwestern Hwy., #101
Farmington Hills, MI 48334
Phone (248) 865-4444
Fax (248) 865-6161



Otolaryngology

Call This Top 10 Community Home

M
McFarland Clinic PC

- daVinci Robot and the Olympus Video System
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- New state-of-the-art minor procedure room
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- Established, collegial team and support staff
- Physician owned and governed
- Large, established referral network
- One of the least litigious states in the country



Featured 9th in Money Magazine's "Best Places to Live", Ames, Iowa is recognized as an active, friendly community with plenty to do. Ames is a vibrant university town with one of the highest-rated public school systems in the nation. Having close access to several major metropolitan cities means that this versatile community provides small-town serenity and charm plus big-city amenities and culture.

EEO/AA Employer/Protected Vet/Disabled

Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

THE CHARLESTON COURSE

4th Annual Otolaryngology Literature Update 2014
MEDICAL UNIVERSITY OF SOUTH CAROLINA

At the Beach!
July 11 - 13, 2014
KIAWAH ISLAND GOLF RESORT, KIAWAH ISLAND, SC


How does a busy clinician stay current in our rapidly expanding specialty?

Our 4th Annual Literature Update Course is designed to help!

- Expert critical assessments of over 100 of the past year's most relevant, current evidence-based publications
- Lectures and discussions that will evaluate best practices and strategies for how to translate the evidence into practice

Our faculty members will cover the entire specialty in 15 lectures over 3 half days with emphasis on the "pearls" important to your practice. We hope you will join us in a beautiful location along the South Carolina coast this July!

Paul R. Lambert, M.D.
Paul R. Lambert, M.D., Professor & Chair

 Otolaryngology - Head & Neck Surgery
Contact: 843-876-0943 • Email: mansfree@musc.edu
<http://ENT.musc.edu>

Otolaryngologist Opportunity

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position


- Take part in the growth of this dynamic department
- Benefit from support from advanced practitioners as well as two on-staff audiologists
- Pursue research in your area of interest



Medical school loan repayment and residency and fellowship stipends are available.

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. GWV is affiliated with an accredited otolaryngology residency program.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, please visit geisinger.org/careers or contact: **Autum Ellis, Department of Professional Staffing**, at 1-800-845-7112 or amellis1@geisinger.edu.



Follow us:   Geisinger is a drug-screening employer; EOE/M/F/D/V



Join a well-established practice in Alabama.

ENT practice is seeking a BC/BE Otolaryngologist to join our current 12 physicians July 2015.

Premier Medical is one of the largest multi-specialty eye, ear, nose & throat groups in the southeast. The diverse practice includes an Audiology & Allergy Department, an in-house CT scanner and is associated with a surgery center.

On-call schedule would include – Once every 6 week days and once every 12 weekends. This position offers a comprehensive benefit package and a competitive salary.

Mobile is the second largest metropolitan area in Alabama and is located only 30 miles from the Gulf of Mexico. The region offers an abundance of cultural & recreational opportunities for everyone - affordable living, arts, hunting, fishing, sailing, good schools and is a family friendly environment. A great place to live & work!

Interested individuals should send CV to or may contact:

Jimmy Hartman
2880 Dauphin Street
Mobile, AL 36606
251-341-3406 • jhartman@pmg.md
www.pmg.md



Faculty Position, Pediatric Otolaryngology *Department of Otolaryngology-Head and Neck Surgery*

Rutgers New Jersey Medical School, Department of Otolaryngology-Head and Neck Surgery is recruiting a fellowship-trained Pediatric Otolaryngologist faculty member for July 2014. The successful applicant will join a rapidly growing academic department, and will be expected to contribute to its clinical, educational and research activities. The faculty member will split his/her time between our practices at Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center and Rutgers New Jersey Medical School campus. The Department houses the only allopathic residency training program in New Jersey and collaborates with an extensive array of health care providers across the Rutgers Biomedical and Health Sciences units.

Applicants for this position must be able to perform at a high level both clinically and academically. Salary will be commensurate with ability, training, experience and demonstrated prior performance, and is designed to attract an outstanding physician and surgeon.

Submit inquiries and current Curriculum Vitae to:

Soly Baredes, M.D.
Professor and Chairman

Huma Quraishi, M.D.
Director of Pediatric
Otolaryngology

Aaron Hajart, MS, ATC
Sr. Director of Administration

Rutgers New Jersey Medical School
Department of Otolaryngology-Head and Neck Surgery
90 Bergen Street, Suite 8100, Newark, NJ 07103
(973) 972-2341 • hajartaf@njms.rutgers.edu



JOIN THE PROMEDICA FAMILY

Otolaryngologist Opportunity in Toledo, Ohio

ProMedica Physicians Ear, Nose and Throat is seeking highly motivated, personable BC/BE otolaryngologists to join their progressive and expanding practice. The practice consists of six ENT physicians and is the only ENT practice in Toledo with fellowship-trained otolaryngologists in head and neck surgical oncology and neurotology. We offer a full range of services including allergy testing and treatment, and complete audiology and vestibular services including ENG, rotary chair, posturography, and cochlear implantation and mapping.

We are seeking candidates who excel at general ENT or with advanced subspecialty interest and fellowship-trained in head and neck surgical oncology and laryngology.

- Full employment with ProMedica Physicians
- "Built in" referral base and high volume
- Call shared equally among all members (currently 1:6)

- Trauma call is optional and paid separately
- Opportunity for teaching residents and medical students
- All members participate in weekly board meetings
- Competitive compensation and generous benefits package
- Relocation paid up to \$10K
- Perfect balance of work and lifestyle

Toledo, Ohio is home to an extensive Metropark system, Toledo Zoo, Toledo Museum of Art, and excellent institutions of higher education.

Contact: Denise Johnston, physician recruiter, at
419-824-7445, denise.johnston@promedica.org.

ProMedica is a tobacco-free employer. EOE

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Louis Stokes Cleveland VA Medical Center
in partnership with Case Western Reserve University:

Otolaryngologist/ Head & Neck Surgical Oncologist

The Louis Stokes Cleveland VA Medical Center (LSCVAMC) is seeking a full time academic Otolaryngologist-Head & Neck Surgeon in the OTO-HNS section of the department of Surgery at the level of assistant, associate, or full professor.

The successful candidate will have either fellowship training in head and neck surgical oncology or at least 2 years' post-residency experience practicing as a head & neck surgeon.

The position involves running the clinical head & neck cancer program at the LSCVAMC and also includes directing the Head & Neck multidisciplinary tumor board. The successful candidate must possess excellent patient care and operative skills and have a strong interest in educating residents and medical students.

The VA and CWRU both place a strong emphasis on research. Accordingly, the preferred candidate will have the skills and interest to develop a research program in head & neck surgical oncology in either the clinical or basic sciences. He or she will be given protected time to ensure success in this objective. The individual who takes this position will have an academic appointment at Case Western Reserve University School of Medicine.

Interested candidates should submit their curriculum vitae at
www.USAJobs.gov
and reference vacancy identification number:
1024055.

THE UNIVERSITY OF NEW MEXICO

Department of Surgery, Division of Pediatric Otolaryngology

The Department of Surgery, Division of Otolaryngology, at the University of New Mexico is seeking a Pediatric Otolaryngologist who is trained in all aspects of pediatric otolaryngology surgery. This position will be recruited at the Assistant/Associate Professor level. Research opportunities are available if desired, and clinical research opportunities are readily available. Appointment and salary will be commensurate with level of experience.

The successful candidate will participate in an active Pediatric Otolaryngology practice, as well as provide resident teaching rounds, medical student teaching and participation at local and national conferences. It is an excellent opportunity for a pediatric otolaryngologist interested in academic achievements and good clinical experience. An excellent compensation package is provided.

Minimum Qualifications: Medical doctor who is board certified/eligible in Otolaryngology-Head and Neck Surgery, eligible for licensure in New Mexico, and eligible to work in the U.S.

Preferred Qualifications: Academic/clinical experience and completed fellowship in Pediatric Otolaryngology, or completing a fellowship in the next twelve months.

Interested applicants must apply for this position via UNMJobs website, unmjobs.unm.edu/, Posting# 0824589. Please attach electronic copies of a current CV and a letter of interest to the application.

In addition, please submit three (3) letters of reference to the email address below. Applications will not be considered complete until all three (3) letters of reference are received. This position will remain open until filled; however, for best consideration, application materials should be received by June 01, 2014. For more information and to submit letters of reference, please contact Erica Bennett, M.D., at EBennett@salud.unm.edu.

The UNM School of Medicine is an Equal Opportunity/Affirmative Action Employer and Educator. This position may be subject to criminal records screening in accordance with New Mexico state law. J1 Visas are not eligible for this opportunity. UNM's confidentiality policy ("Disclosure of Information about Candidates for Employment," UNM Board of Regents' Policy Manual 6.7), which includes information about public disclosure of documents submitted by applicants, is located at <http://www.unm.edu/~brpm/r67.htm>

South Florida Associates, P.A.

South Florida ENT Associates, a forty-seven physician group practice in Miami-Dade, Broward and Palm Beach has immediate openings for full-time ENT Physicians. South Florida ENT Associates is the second largest ENT group in the country and the largest in the state of Florida. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics and CT services.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.

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
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills
F/T - M-F plus call

For more information about us, please visit www.sfenta.com.

Contact Information:

Contact name: Stacey Citrin, CEO
Phone: (305) 558-3724 • Cellular: (954) 803-9511
E-mail: scitrin@southfloridaent.com

BEAUTIFUL MIDWEST CITY

I am looking for an otolaryngologist to join my very rewarding and active practice of general otolaryngology with a special interest in otology. I am also offering the opportunity for someone to assume a turn-key practice upon my retirement.

The practice currently has approximately 50-60 tympanomastoidectomies throughout the year as well as a broad range of general otolaryngology such as tonsillectomies, adenoidectomies and tubes, as well as sinus and skin surgeries.

Cape Girardeau, MO is a thriving, progressive city that has been relatively untouched by economic downturns, and the overall unemployment rate for the county is at 5%. The city has a population of about 40,000 people; it grows to over 100,000 during any given day as a business center of southeast Missouri and with the location of Southeast Missouri State University. It attracts referrals from physicians, clinics and nurse practitioners in a radius that includes approximately 250,000 people.

There are two well equipped, up to date hospitals in town as well as several surgery centers, all of which would give a spectrum of opportunity for an incoming otolaryngology head and neck surgery physician.

Interested applicants are encouraged to contact me directly.

Richard A. Martin, M.D., F.A.C.S.

Office (5773) 332-7000

Cell (573) 450-4189

Home (573) 243-5306

MARTIN EAR NOSE & THROAT CLINIC

Richard A. Martin, M.D., F.A.C.S.

3117 Blattner Drive • Cape Girardeau, MO 63703

Phone 573-332-7000 • Fax 573-332-7005

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Pediatric Otolaryngologist - We are seeking a fellowship-trained, board eligible/certified individual to join a high-volume practice. This position will be recruited at the Assistant/Associate Professor level. It is an excellent opportunity for a Pediatric Otolaryngologist interested in academic growth and excellent clinical experience.

Candidates must be able to obtain a Tennessee medical license.

Letters of inquiry and curriculum vitae should be sent to:

Jerome W. Thompson, M.D., MBA, Chairman
Department of Otolaryngology-Head and Neck Surgery
The University of Tennessee Health Science Center
910 Madison Avenue, Suite 408
Memphis, TN 38163

Or email to: jkeys@uthsc.edu

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

Are you more interested in building a legacy than just finding a job?

The Department of Otolaryngology at West Virginia University is seeking a **general 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.

You'll join a highly skilled team making an extraordinary difference in the lives of patients across our entire state. Ours is a collaborative atmosphere that encourages you to grow and evolve as you practice advanced medicine in a highly satisfying academic setting.

The department currently has thirteen physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

U.S. News & World Report ranked West Virginia University Hospitals in Morgantown #1 in the state for the last two years. Forbes recently ranked Morgantown as one of the Best Small Metros in America. Our 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.

Build your legacy as you serve, teach, learn and make a difference from day one. To learn more, visit <http://medicine.hsc.wvu.edu/otolaryngology/Home> or submit your CV directly to Laura Blake, Director of Physician Recruitment, at blakel@wvuhealthcare.com.



WVU is an AA/EO employer and is the recipient of an NSF ADVANCE award for gender equity.
Position will remain open until filled.

Boise, Idaho

Please contact: Ryan L. Van De Graaff, M.D.
Southwest Idaho Ear, Nose & Throat, PA
900 N. Liberty St., Ste 400 • Boise, ID 83704
208-367-7405
E-mail: rvdg@swient.com

Six-physician single specialty group seeking a partner with BC/BE physician interested in general ENT with Laryngology emphasis. Fellowship training preferred but not required. Successful practice provides broad spectrum of ENT care with subspecialties in rhinology, head and neck surgery, facial plastic and reconstructive surgery. Our 16,000 square foot facility includes an AAAHC approved Surgery Center, an in-house CT scanner, full service Audiology and Allergy departments. Office is adjacent to a regional medical center.

Compensation package includes a first year salary with productivity incentives and the opportunity for partnership after the 1st year.

Boise is often cited as one of the top 10 best cities in which to live. It is a safe, family-oriented community with an excellent education system and a wonderful climate. Boise's Rocky Mountain location offers plenty of recreational activities including skiing, white water rafting, mountain biking, fishing, hunting, etc.

OTOLARYNGOLOGIST FACULTY POSITION

UMass Memorial Medical Center, the clinical partner of the University of Massachusetts Medical School in Worcester, MA, is seeking a BC/BE general otolaryngologist. An interest in head and neck, otology, or pediatric otolaryngology is welcome. Join an established group of 6 physicians in a busy tertiary care referral center. Responsibilities include clinical care as well as student and resident education. Opportunities exist for clinical and basic science investigation and research. An academic appointment commensurate with education and training is offered.



We are looking for a dynamic new or recent graduate with energy, desire and drive to expand our presence.

Worcester is the second largest city in Massachusetts and in 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 is only forty miles away, and lakes, beaches and mountains are all easily accessible.

Interested applicants should submit a CV and letter of interest to:

Daniel Kim, MD
Chair of Otolaryngology-Head and Neck Surgery
UMass Memorial Medical Center
c/o Carolyn Jacobs,
Physician Recruiter
Carolyn.Jacobs@umassmemorial.org
Telephone: 774-442-9412



As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.

Joe Dimaggio Children's Hospital Seeks Pediatric Otolaryngologist

About the Opportunity:

The Division of Pediatric Otolaryngology-Head & Neck Surgery at Joe DiMaggio Children's Hospital seeks a motivated board-certified/board-eligible fellowship-trained pediatric otolaryngologist interested in growing our rapidly expanding tertiary care division. The Division of Pediatric Otolaryngology is a robust outpatient and hospital-based program, with dedicated pediatric audiology, mid-level practitioners and a diverse patient population. We have an established aerodigestive team and cochlear implant center as well as pediatric videostroboscopy in addition to the busiest Craniofacial Center in Florida. Qualified candidates should have an interest in head and neck, airway, vascular malformations or otology. Excellent opportunities exist for interdisciplinary collaboration, program development, research and teaching. We have a new affiliation with a four (4) year Allopathic Medical school. Emergency room call is 1:7.

About Joe DiMaggio Children's Hospital:

Joe DiMaggio Children's Hospital, a 204-bed facility, opened in 1992 and is located in Hollywood, Florida. As South Florida's newest freestanding children's hospital, Joe DiMaggio Children's Hospital is redefining the pediatric healthcare experience. We combine cutting-edge excellence with a commitment to patient- and family-centered care, and have the largest and most diverse group of board-certified pediatric specialists in the region. Thanks to exemplary medical expertise, advanced technology and exclusive pediatric programs, JDCH has earned the distinction of being the leading children's hospital in Broward and Palm Beach counties. JDCH is the only Pediatric Trauma Center in South Broward County and is dedicated to the physical and emotional care of children. We're continuing to pioneer revolutionary programs that define the standard in pediatric care. To learn more, please visit JDCH.com.

About South Florida:

South Florida offers an outstanding quality of life rich in cultural and recreational amenities. Residents enjoy pristine beaches, top-rated golf courses, museums, world-class dining and myriad family-friendly communities. Further, Florida also has no state income tax.

Please submit CV and letter of interest to:
jdchdoctor@mhs.net

FELLOWSHIP TRANSORAL SURGERY MICROVASCULAR HEAD & NECK RECONSTRUCTION HEAD AND NECK ONCOLOGY

Washington University School of Medicine in the Department of Otolaryngology is seeking applicants for a one-year fellowship starting July 1, 2015. This excellent high volume fellowship provides in-depth exposure to a broad variety of advanced microvascular reconstructive head & neck techniques, transoral resections (TLM and TORS), and skull base surgery. Applicant must be able to obtain a Missouri State license and must be board eligible. Salary and benefits according to PGY year. License expenses also covered.

Send inquiries and curriculum vitae to:

Bruce H. Haughey, MBChB & Brian Nussenbaum, M.D.

Division of Head and Neck Surgical Oncology
Washington University School of Medicine
Department of Otolaryngology Head and Neck Surgery
660 S. Euclid Ave.
Campus Box 8115
St. Louis, MO. 63110
Phone 314/362-0365
Fax 314/362-7522
<http://oto.wustl.edu>

Are you more interested in building a legacy than just finding a job?

The Department of Otolaryngology at West Virginia University is seeking 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.

You'll join a highly skilled team making an extraordinary difference in the lives of patients across our entire state. Ours is a collaborative atmosphere that encourages you to grow and evolve as you practice advanced medicine in a highly satisfying academic setting.

The department currently has thirteen physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

U.S. News & World Report ranked West Virginia University Hospitals in Morgantown #1 in the state for the last two years. Forbes recently ranked Morgantown as one of the Best Small Metros in America. Our 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.

Build your legacy as you serve, teach, learn and make a difference from day one. To learn more, visit <http://medicine.hsc.wvu.edu/otolaryngology/Home> or submit your CV directly to Laura Blake, Director of Physician Recruitment, at blakel@wvuhealthcare.com.



WVU is an AA/EEO employer and is the recipient of an NSF ADVANCE award for gender equity.
Position will remain open until filled.

Full Time Faculty Opportunities University of Rochester Medical Center

Clinician-Scientist / Neurotologist

BC/BE, fellowship trained boarded neurotologist with appropriate research training at any rank is sought to develop an outstanding clinical practice and externally funded research program and join three other practicing neurotologists. Applicants must also contribute to resident and medical student education. Basic, translational, or patient-oriented research programs are desired. Protected research time and resources are available.

Pediatric Otolaryngologist

BC/BE, fellowship trained pediatric otolaryngologist at any rank is sought to practice at the brand new Golisano Children's Hospital, opening in 2015. This position offers excellent opportunities to practice the full range of the specialty in state of the art facilities. Resident teaching is expected and scholarly activities strongly encouraged. Protected research time and resources are available for candidates seeking a career as a clinician-scientist.

General Otolaryngology

BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support.

Our robust clinical practice and training program is affiliated with the University of Rochester Medical Center's Strong Memorial and Highland Hospitals. These are excellent opportunities to practice with an established group of academic faculty who already have practices in all Otolaryngology subspecialty areas, in a growing academic department.



The University of Rochester is an affirmative action/equal opportunity employer and strongly encourages applications from women and minorities.

Interested candidates should send their curriculum vitae and letter of interest to:

Shawn Newlands, M.D., Ph.D., M.B.A., F.A.C.S.
Professor and Chair
Department of Otolaryngology
Strong Memorial Hospital
601 Elmwood Avenue, Box 629
Rochester, NY 14642
(585) 758-5700
shawn_newlands@urmc.rochester.edu



Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

CHIEF OF PEDIATRIC OTOLARYNGOLOGY AT WEILL CORNELL/NEW YORK-PRESBYTERIAN

Excellent growth opportunity for a motivated leader

Opportunities include:

- Dynamic Top-10 academic hospital and Ivy League medical college with new research building opening, and new outpatient center in progress.
- Large department with multiple growth opportunities including new outpatient practice locations on the Upper West Side and Lower Manhattan.
- Primary practice location in desirable Upper East Side of Manhattan with state-of-the-art pediatrics-only specialty space.
- Inpatient and OR at New York-Presbyterian Hospital/Weill Cornell Medical Center on the Upper East Side.
- New hospital site: New York-Presbyterian/Lower Manhattan Hospital, in prime growth location.
- Large Department of Pediatrics with all surgical and medical subspecialties represented.
- Busy NICU and PICU receiving tertiary referrals from multiple network hospitals.
- Peds Oto is within a large collaborative department with multiple areas of subspecialty expertise for collaboration.
- Opportunity to build a pediatric fellowship program.
- Outstanding junior faculty in place.
- Faculty housing available.

**If interested, please contact Kim Ocasio at <kio2004@med.cornell.edu>.
EOE M/F/D/V**

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