NOSE ARS American Rhinologic Society NEWS

PRESIDENT'S MESSAGE

SUMMER 2006

Michael Sillers, MD
ARS President

I hope that each of you is enjoying springtime so far and making plans to joins us in Chicago for the ARS scientific session at COSM May 18-20. Howard Levine and the Program Committee have put together an excellent program. There are over 30 clinical and basic science papers as well as poster presentations. The Patient Advocacy Committee will present a panel discussion on relevant coding and reimbursement topics. I know that these venues will provide outstanding CME opportunities and help you answer questions about difficult and at times controversial coding issues.

I had the opportunity to attend our Academy's Washington Advocacy Conference in March. If you have not participated in this meeting I would recommend that you consider doing so in the future. There were three highlights. The subspecialty societies' leadership met with American Board of Otolaryngology (ABOto) leaders Drs. Pillsbury, Miller, and Medina in an open forum roundtable. The discussion focused on the maintenance of certification (MOC) exam. There has been significant evolution in this process as ABOto has learned from successes and failures of other specialty society boards. There is unanimous agreement that our success will depend on subspecialty society cooperation and active involvement in the development of appropriate examination materials. The ARS is committed to this process and welcomes your input and participation.

The second highlight was the President's breakfast hosted by Academy President Ron Cannon. David Nielsen discussed Pay-for-Performance and the critical need for our Academy, its members, and subspecialty societies to be proactive rather than reactive. We run the risk of having performance measures thrust upon us. Our Academy is sponsoring the TRICSM Conference (Translating Research Into Cross-Specialty Measures Conference) June 22-24, 2006, in Arlington, VA. The purpose of this conference is to encourage members of different specialties to cooperate in establishing measures of disease management and quality outcomes. This is an important issue and our active involvement is critical. The ARS will plan to have representation at this meeting.

The third highlight was a review of data compiled from the Academy's most recent work force study group preliminary questionnaire. This was an online survey sent to 319 members with an impressive 54 % response rate during an eight day period. These data are extremely important for our specialty in terms of planning today for adequate otolaryngologic care 10-20 years from now. It is also important for subspecialty societies, like the ARS, in assisting with the future direction of fellowship training programs. I encourage each of you to become actively involved in our Academy and participate in surveys such as this in the future.

I am proud to be an active member of our Academy. Also, I firmly believe that membership and involvement in the American Rhinologic Society complements the work of our Academy in many ways. Please look for opportunities to become a participating member and I encourage you to join us at COSM.

IN THIS ISSUE...

THE AMERICAN RHINOLOGIC SOCIETY'S RESEARCH AWARDS

Allen M. Seiden, MD, *Chair, Awards Committee*

Part of the mission of the American Rhinologic Society has always been to promote research and clinical study in the field of rhinology. The society has grown dramatically over the last two decades, and with this growth has emerged a greater interest in such research. This is evidenced by the increasing volume and quality of papers presented at our meetings, and the quality of papers published in our flagship journal, The American Journal of Rhinology.

To this end, the American Rhinologic Society has traditionally offered several awards for outstanding research papers presented at the fall and spring annual meetings. The Cottle Award was initiated not only to acknowledge the best clinical or basic science research paper at the fall meeting, but also to honor Dr. Maurice Cottle, the founder of our society. Also presented at the fall scientific meeting is the International Rhinology Research Award. Recognizing that physicians outside the United States may have difficulty attending the American Rhinologic Society's scientific meetings, this award was created four years ago to invite valuable contributions from international non- U.S. physicians.

At the annual spring meeting, only one award has traditionally been offered, the American Rhinologic Society Research Award. It has become clear, however, that in this format basic science research papers tend to take precedence over clinical research papers. While the former tend to attract more research dollars and prestige, the latter are no less valuable in what they can bring to benefit physician understanding and patient care. Therefore, beginning this spring, the American Rhinologic Society will be offering two awards at the scientific meeting: The **ARS Basic Science Research Award**, awarded for the best basic science research paper presented at the spring ARS scientific meeting, and the **ARS Clinical Research Award**, awarded for the best clinical research paper presented at the spring ARS scientific meeting.

All awards are for $1000.00, and the winners are announced during the meeting at which time the primary author is presented with a certificate. Everyone submitting an abstract to either the fall or spring meeting is eligible to be considered for an award, once the paper is accepted by the Program Committee. A separate submission is not required. Those papers given the highest ranking by the Program Committee are evaluated by the Awards Committee members, who are all blinded as to the papers' authors, and a winner is selected. Please consult the Society's website for appropriate submission deadlines and further details.

Join the ARS today!

American Rhinologic Society

Upcoming Events and Deadlines:

May 19-20, 2006
ARS Spring Meeting, Chicago

August 1, 2006
ARS Annual Scientific Meeting
Abstract Submission Deadline

September 16, 2006
ARS Annual Scientific Meeting,
Toronto

December 15, 2006
Letter of Intent Deadline,
ARS CORE Research Grants

January 15, 2007
Application Deadline,
ARS CORE Research Grants

SAHP UPDATE: WHAT'S UP?

Timothy Smith, MD, Joe Jacobs, MD, and Howard Levine, MD

The Sinus and Allergy Health Partnership (SAHP), comprised of representatives from the American Rhinologic Society (ARS), the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and the American Academy of Otolaryngic Allergy (AAOA), remains active on your behalf. This critical collaboration between our societies allows for important initiatives to be undertaken on behalf of all otolaryngologists practicing nasal and sinus medicine and surgery. The current SAHP Board has established the primary goals of the partnership as follows:

- Enhance national and international visibility for otolaryngology research in the arena of sinonasal disease
- Promote otolaryngologists as the providers of sinonasal care through publications and education
- Build relationships and enhance communication between the ARS, AAO-HNS, and AAOA to advance sinonasal care in the field of Otolaryngology-Head and Neck Surgery

To this end, several important initiatives are underway:

Research Grant Funding: Our specialty should be at the cutting edge of sinonasal research. The SAHP, through the AAO-HNSF CORE grant mechanism, has requested applications for a research grant focused on sinonasal disease. The grant is intended to fund junior or mid-level investigators who have completed their training and intend to obtain preliminary data for subsequent extramural grant funding (e.g. National Institutes of Health grants). The SAHP believes it is critical to help fund important research by promising investigators in our specialty who will go on to develop the next generation of tools for the management of sinonasal disease. More information about this request for applications and other ARS research grants can be found on the AAO-HNS website (http://www.entlink.net/research/grant/Foundation-Funding-Opportunities.cfm).

ABRS Updates: The SAHP is currently laying the groundwork for the next edition of the Antimicrobial Treatment Guidelines For Acute Bacterial Rhinosinusitis (Otolaryngol Head Neck Surg. 2004 Jan;130(1 Suppl):1-45). The new Guidelines will focus upon an evidence based approach to recommendations for the management of ABRS. These important guidelines attract attention from numerous medical specialties and highlight the critical role of otolaryngologists in the management of sinonasal disease.

Communication between the Societies: Since the SAHP is simply a collaboration of the ARS, AAOA, and AAO-HNS, communication between the SAHP and these founding societies is key to sustained success. The SAHP continues to reinvigorate itself with new ideas and initiatives of interest to all three societies and all otolaryngologists. This process enhances communication and collaboration between the Societies for the benefit of all of otolaryngology.

Current SAHP Board with affiliation

Edwyn Boyd, MD	AAOA
Karen Calhoun, MD	AAO-HNS
Stephen Chadwick, MD	AAOA
Jack Fornadley, MD	AAOA, SAHP Treasurer
Richard Haydon, MD	AAO-HNS
Joseph Jacobs, MD	ARS
Howard Levine, MD	ARS, SAHP Chair
Bradley Marple, MD	AAO-HNS
Timothy Smith, MD	ARS
Jami Lucas	SAHP Secretary
Will Shawver	Point Staff Person Supporting SAHP

For further information regarding the SAHP, feel free to contact its' staff, William Shawver, or Executive Director, Jamie Lucas, at 202-955-5010 (fax 202-955-5016; 1990 M Street, NW, Suite 680, Washington, DC 20036).

2006 ARS CORPORATE AFFILIATE RESEARCH GRANT PROGRAM PARTICIPANTS

Platinum ($10,000)

Aventis
Gyrus ENT

Gold ($5,000)

Karl Storz Endoscopy
Abbott Laboratories
Naryx Pharma, Inc.

Silver ($2,500)

Medtronic-Xomed

Bronze ($1,000)

GE Medical Systems
Navigation & Visualization

Richard Wolf Medical
Instruments Corp.

THE AMERICAN RHINOLOGIC SOCIETY'S COMMITTEE ROSTER
SEPTEMBER 2005 - SEPTEMBER 2006

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Rodney Schlosser, MD 2/3
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Karen Fong, MD 2/3
Todd Kingdom, MD 2/3

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Welcome New Members

The following colleagues have recently joined our society:

International Members

Toru Kikawada
Masato Miwa

Regular Members

Jose M. Busquets
David R. Brown
Joseph E. Hart
Umang Khetarpal
John A. Lindgren
Abraham T. Manoj
Thomas A. Simpson
Richard W. Westreich
Allison N. Wyll

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Stacey T. Gray

Resident Members

Johon W. Alldredge
Jeevan Ramakrishnan
Kevin C. Welch

COMMITTEE PARTICIPATION - THE KEY TO A HEALTHY SOCIETY

Brent A. Senior, MD, *ARS Secretary*

Thank-You! To the nearly 70 members of the ARS who take the additional time and effort to participate in 20 committees and sub-committees that aid your society, I want to offer my sincerest gratitude. Committees form the lifeblood of our society, allowing members to participate in a very practical way in society function, and, therefore, tangibly impact the care of our rhinology patients. Indeed, the strength of our committee structure has really been at the root of the overall societal success seen over the last several years.

I wish to highlight three committees that have been particularly active in setting the course for our society. The Patient Advocacy Committee, under the chairmanship of Drs. Jacobs, Sillers, and currently, Setzen, has been a potent force working on behalf of our rhinology patients. Frequently on the front lines, it is this committee that moves into action when coding and reimbursement issues develop: writing letters, consulting with attorneys, and meeting with government agencies such as CMS. Over the last several years, issues that have been addressed (among many others) include proper reimbursement for use of computer aided surgery in the ambulatory surgery center setting, in addition to the development of guidelines and policy statements for the use of computer aided surgery for sinus surgery and endoscopic debridement following endoscopic sinus surgery.

The Education Committee, under the chairmanship of Winston Vaughan, and more recently, Todd Kingdom, has been tackling the challenging issues surrounding postgraduate education in rhinology including rhinology fellowship training. The committee has served to aid applicants by providing a common information source regarding fellowships as well as streamlining the application and interview process. Developing a standard set of fellowship criteria for review by candidates in addition to standardized interview dates and offer dates, the committees efforts resulted in the first ever "Fellowship Link" occurring in 2005.

The Information Technology Committee, under the chairmanship of Martin Citardi has been remarkable in developing a web presence for our society, an information resource for our patients, and improving our communication with the membership. Abstract and manuscript submissions have been completely transferred to electronic format greatly speeding review and decisions. Indeed, this committee's efforts have been so successful that, arguably, our society's internet presence may be the best of any sub-society within ENT.

I want to commend the efforts of all of our committees and the hard work and time they invest on behalf of our society and our patients. But even more, I want to encourage our ARS members to consider participating as well. If you would like to help to make your society stronger and a better voice for our patients, please feel free to notify our society administrator, Wendi Perez, of your interest. Committee participation is truly the key to a healthy ARS.

CASE OF THE QUARTER: ENDOSCOPIC RESECTION OF A SINONASAL ADENOID CYSTIC CARCINOMA INVOLVING THE ANTERIOR SKULL BASE

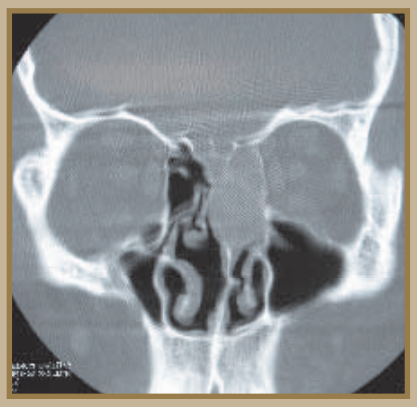
Dan Jethanamest, Satish Govindaraj MD, Noam A. Cohen MD, PhD, Alexander G. Chiu MD

Introduction

The term "cylindroma" was first used to describe the histologic appearance of adenoid cystic carcinoma by Billroth in 1859. Adenoid cystic carcinoma is a relatively uncommon tumor that has a slow but progressive course. It represents less than 1% of all malignancies in the head and neck and is most commonly associated with the minor salivary glands (60%). Adenoid cystic carcinoma accounts for 5-15% of all paranasal sinus malignancies.

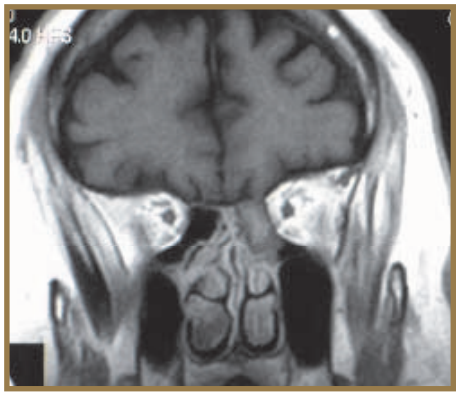
Case

A 67 year-old man was referred to our institution with left middle meatal polyps. A CT scan revealed a left sided nasal mass with erosion of the superior nasal septum and abutment of the mass to the skull base. Given the erosive nature of this lesion, a biopsy was performed in the office and was read with a differential diagnosis of adenocarcinoma versus a primary salivary gland tumor. A fine cut CT scan was ordered which showed evidence of a left nasal mass that eroded through the superior nasal septum and abutted the cribiform plate on the left as well as the right nasal cavity. A MRI of the brain and orbits revealed no evidence of intracranial extension or dural enhancement. An endoscopic resection of the tumor was planned, with resection of the bony anterior skull base and dural biopsies to rule out intracranial involvement.



The patient had a lumbar drain placed prior to the operation and 0.1 cc of 10% IV fluorescein dye was injected into the intrathecal space. The tumor was found to *cont. on pg. 6*

arise from the left superior nasal septum and middle turbinate with superior extension to the cribiform plate bilaterally. The tumor was debulked with a microdebrider to visualize its point of attachment at the superior nasal septum and middle turbinate. Complete resection was performed including a complete left sphenoethmoidectomy, superior septectomy, transseptal frontal sinusotomy, and resection of the lamina papyracea and anterior cribiform plate. Multiple tumor margins were taken including underlying dural and periorbital biopsies which were negative for tumor. Multiple CSF leaks were created following the dural biopsies and a multi-layered temporalis fascia graft, fibrin glue and microfibrillar collagen packing was used to reconstruct the skull base. A Merocel® sponge was placed to support the packing and two nasal trumpets were placed to divert airflow from the nasal cavity. The patient's postoperative course was uneventful with removal of the lumbar drain postoperative day 2 and discharge postoperative day 6 after removal of the nasal trumpets. Three months following surgery he is receiving radiation therapy to the skull base and has no evidence of residual or recurrent disease.



Discussion

Adenoid cystic carcinoma (ACC) is a slow growing but progressive disease that is difficult to effectively treat. The tumor frequently recurs locally, has a tendency for perineural spread, and can metastasize distantly, making cure elusive although patients may often live extended time periods even with metastatic disease.

Radiographically, these tumors should be evaluated by both CT and MRI. Since ACC has a predilection for perineural spread, MRI should be part of the preoperative evaluation. On T1-weighted imaging, these neoplasms most often have an intermediate signal intensity, while T2 can be variable depending upon the cellularity of the tumor. Lesions with greater cellularity tend to produce intermediate signal, while less cellular tumors, with greater stromal areas, appear hyperintense. Signs of perineural spread include: nerve enlargement, irregularity or enhancement; loss of the high T1 signal of fat pads surrounding nerves in their foramina; and muscle denervation.

In the paranasal sinuses and nasal cavity, adenoid cystic carcinoma is treated with a combination of complete surgical resection and adjuvant radiotherapy. Naficy has reported an overall survival rate of 73% in sinonasal ACC treated with surgery and adjuvant radiation therapy. Although aggressive treatment is recommended, the natural course of this process described as indolent with late recurrence has not been altered by present treatment modalities.

Sinonasal malignancies extending to the anterior skull base present unique challenges for treatment due to the limits of anatomical exposure and sensitivity of surrounding structures. The endoscopic resection of sinonasal malignancies is an evolving area as endoscopic instrumentation and surgical experience matures. A review of 47 patients treated by an endoscopic approach by Roh et al. at the Cleveland Clinic and the University of Pennsylvania found that local recurrence, overall survival, and disease-free survival in their cohort compared favorably to published rates for patients undergoing anterior craniofacial surgery.

This tumor's location and confinement to the sinonasal compartment made endoscopic resection an ideal choice for treatment with the least morbidity. Due to this disease's natural history, long term follow up for both local and distant metastases must be performed.

References:

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Gandhi D, Gujar S, Mukherji SK. Magnetic resonance imaging of perineural spread of head and neck malignancies. *Top Magn Reson Imaging* 2004;15:79-85.

Roh HJ, Batra PS, Citardi MJ, Lee J, Bolger WE, Lanza DC. Endoscopic resection of sinonasal malignancies: a preliminary report. *Am J Rhinol* 2004;18:239-246.

PATIENT ADVOCACY CORNER - UNLISTED CODES

Michael Setzen, MD, FACS, *Chair, Patient Advocacy Committee; Member-At-Large ARS Board of Directors*
Richard Waguespack, MD, FACS; *Chair, CPT & Relative Value Committee, AAO-HNS; Member, AMA CPT Editorial Panel*
Linda Taliaferro, *MHCM; Business Unit Director, Health Policy, AAO-HNS*

"How do I code a procedure for which there is no existing CPT Code?"

This is a perplexing problem facing our members every time an operative procedure is performed for which no CPT code exists. With the advent of the endoscope, many traditionally open procedures are now being performed endoscopically rather than via the open approach. Examples of this include endoscopic sphenopalatine artery ligation, endoscopic skull base surgery, and endoscopic medial maxillectomy to name but a few.

Let us use the example of endoscopic transnasal sphenopalatine artery ligation and examine the following options:

31238-22 Nasal/Sinus Endoscopy, Surgical; with control of nasal hemorrhage (RVU=5.63; 0 Day Global Period): To paraphrase the vignette for 31238: The patient has epistaxis which has not been controlled with nasal packing and will usually have a bleeding source in the posterior nasal cavity from the posterior ethmoid artery or a branch of the sphenopalatine artery. Quoting from CPT 2006, "Modifier 22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate."

30920-52 Ligation arteries; internal maxillary artery, transantral (RVU=19.62; 90 Day Global Period): CPT 2006 states the following for modifier 52- Reduced Services: "Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service…."

30999 Unlisted procedure, nose or 31299 Unlisted procedure, accessory sinuses: Unlisted codes do not have defined global periods but it is reasonable to assume a 0-day global which is consistent with existing codes in the family. However, this is ultimately a payer policy determination and may vary from payer to payer.

Each one of these options has advantages and disadvantages:
31238-with modifier 22: This is a reasonable and accurate coding option, however payer reimbursement may be lower than what surgeons feel is consistent with the associated physician work.

30920-with modifier 52: To use this option, the service reported should be fundamentally the same as the base code but "partially reduced or eliminated" as defined above. Professional coders would argue this is not the case in this scenario, and that it violates basic CPT coding principles. Furthermore, the AMA does not encourage the use of an open procedure code when an endoscopic procedure is being performed. Some members of the ARS view this differently and are of the opinion that operating transnasal and endoscopically on the sphenopalatine artery is conceptually similar to transantral and microscopic ligation of the internal maxillary artery.

30999 or 31299-Unlisted Code: This is the option most professional coders would recommend but is most controversial among our members for the following reasons:
1. Members claim they don't get paid.
2. Paper work and documentation may be considered burdensome.
3. Members are uncertain about what charge to attach to the unlisted code. One should choose a relatively close existing code and give justification for its use as the charge benchmark.

All of the options presented above require the following:
1) Claims should be submitted via paper and need an accompanying detailed operative note.
2) The claim will be subjected to medical review and may be delayed weeks in processing. It is recommended that a cover letter accompany these submissions to explain in lay language what service(s) were performed and the justification for the charge submitted. One should create a standard letter and then customize it on a per patient basis.

What about long-term fixes? If CPT code 31238 evolves clinically to describe transnasal endoscopic sphenopalatine artery ligation, it could be editorially changed through the CPT Editorial Panel process and/or revalued through the AMA's Relative Value Update Committee (RUC) process to reflect the change. Requesting a new category I CPT code is not an appealing option at this time. Pursuing a new category I CPT code is a time consuming and costly process. Pursing a category III CPT code (new technology code) is a possibility, however, many members state that they encounter similar reimbursement challenges with a category III code as with an unlisted code.

Ultimately, it is the surgeon who is responsible for the codes submitted. Correct coding is important for many reasons, not the least of which is the potential for audit. Our healthcare system is highly dependent on the appropriate distribution and use of resources through CPT coding. The use of the unlisted CPT code helps with the CPT development process and especially with the relative value unit allocation when a new procedure is proposed for its own code. We recommend asking your individual carriers how they want such a service reported. In addition, the ARS Patient Advocacy Committee and the AAO-HNS Center for Practice Services are available to members for coding and reimbursement advice.

American Rhinologic Society
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9 Sunset Terrace
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UPCOMING RHINOLOGY MEETINGS

Comprehensive Endoscopic Sinus Surgery, — June 23-24, 2006
Johns Hopkins University
Baltimore, Maryland
Contact: JHU Continuing Education: 410.955.2959, cmenet@jhmi.edu, www.hopkinscme.net

AAOA Basic Course — July 6-9, 2006
Vail, Colorado
Contact: 202.955.5010, www.aaoaf.org

Current Techniques in Endoscopic Sinus Surgery Course — July 25-26, 2006
St. Paul's Sinus Center
University of British Columbia, Vancouver, Canada
Contact: UBC Continuing Medical Education: 604.822.7301, www.cpdkt.ubc.ca

AAOA Annual Meeting — September 14-16, 2006
Toronto, Canada
Contact: 202.955.5010, www.aaoaf.org

Southern States of Rhinology Course — October 19-21, 2006
Medical College of Georgia
Contact: Aprell Edwards: 709.721.6100, apedwards@mcg.edu

Western States Rhinology Course — October 26-28, 2006
University of Colorado, University of Utah, Stanford University,
Sonoma, California
Contact: 303.372.9063, www.uchsc.edu/cme

AAOA Advanced Course — December 6-10, 2006
Austin, Texas
Contact: 202.955.5010, www.aaoaf.org

27th International Symposium if Infection & Allergy of the Nose (ISIAN) — June-15-16, 2008
Crete, Greece, *Contact: www.frei.gr*

If you would like to have your upcoming rhinology meeting noted here, simply provide the editor with pertinent information: newsletter@american-rhinologic.org
The American Rhinologic Society does not endorse these meetings but simply provides the list as a service to its members

American Rhinologic Society Newsletter
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