

Quarterly Report

AOCO,
AOCO-HNS &
Foundation, Inc.

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - FALL 2006, Vol. 41 No. 4

Mid-Year Seminar... a Success

The 5th Mid-Year Seminar sponsored by the AOCOO-HNS Foundation held at the Embassy Suites Hotel, Philadelphia Airport on September 9-10 was another successful continuing medical education course. We are proud to announce an attendance of 95 members, residents, interns and medical students.

Special Thanks to

Mahmoud M. Ghaderi, DO
Otolaryngology Program
Chairman

Sirtaz S. Sibia, DO
Ophthalmology Program
Chairman

Speakers

Lana E. Brahmakulam, DO
Alexander G. Chiu, MD
Farhah R. Chowdhury, DO
Austin W. Coleman, DO
Mahmoud M. Ghaderi, DO
Leonard H. Ginsburg, MD
Timothy M. Greco, MD
John D. Gull, DO
Jonathan M. Gusdorff, DO
L. Jay Katz, MD
Raymond W. Lesser, MD
Robert F. Lindberg, DO
Raymond C. Maguire, DO
Louis J. Mariotti, DO
Scott P. Markham, DO
Brian P. Marr, MD
Marlene R. Moster, MD
Mark L. Moster, MD
Shoib Myint, DO
Bosco E. Noronha, MD
Brent R. Rosen, DO
Richard E. Roth, DO
Nicholas A. Sala, DO
Robert T. Sataloff, MD
Donald M. Sesso, DO
Angana N. Shah, MD
James E. Silone Jr., DO
Leonard Skorin Jr., DO
Christin L. Sylvester, DO
Michael T. Teixido, MD
Mikhail Vaysberg, DO
Vincent K. Young, MD

The 6th Mid-Year Seminar will be held at the Westin Airport Hotel, Detroit, Michigan on September 8-9, 2007.

Exhibitors

Alcon Laboratories, Inc.
Allergychoices, Inc.
ArthroCare ENT
Eilman International
InHealth Technologies
IRIDEX Corporation
JEDMED Instrument Co.
Mosby Saunders Elsevier
Pfizer Pharmaceutical Co.

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OPH &
ENT
Practice
Opening

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Views and opinions expressed in the *AOCO-HNS Quarterly Report* are not necessarily endorsed by the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery.

Quarterly Report Schedule

SUMMER: copy deadline May 15th
mailing June 15th
FALL: copy deadline August 15th
mailing September 15th
WINTER: copy deadline November 15th
mailing December 15th
SPRING: copy deadline February 15th
mailing March 15th

PRESIDENTS' REPORTS

AOCO-HNS

American Osteopathic College of Otolaryngology-Head and Neck Surgery
Kenneth H. Rogotzke, DO



In July I attended the AOA House of Delegates meeting. Dr. Alvin Dubin is actually our delegate and I served as the alternate delegate. The AOCO-HNS

was well represented with, of course, Dr. Philip Shettle the immediate past president and also with physicians representing their states. That included Dr. James Zirul-AK, Dr. Carlo DiMarco-PA, Dr. Christopher Surek-LA, and Dr. William Mayo-MS.

At this meeting our proposed bylaw changes were approved and we are now charged with implementing them. That work has begun.

A great deal of the House of Delegates meeting dealt with numerous resolutions. Some of these were quite interesting and applied to our practices. It was clear that this entire process demonstrated the power of the AOA involvement from each state level. It is also clear to me, if you want to improve or protect your practice or help our profession, involvement through these state organizations to the AOA is a worthwhile endeavor. I hope you would be so motivated.

I met with people who are involved in starting new schools in Colorado and Washington. It amazes me that we have all these new schools of osteopathy. It seems to me that we are going to be graduating a lot of students without adequate residency positions. Reviewing published statistics from the past would certainly indicate that an interest in our specialties continues and we should do that is possible to increase the number of residencies available to our graduates. If you need help to develop a program, feel free to call me. There are a few of you out there that we are working with currently and I can assure you the

intent is to establish quality residencies.

Kenneth H. Rogotzke, DO
AOCO-HNS President
605-882-1672
Fax 605-882-1693
Email: rogotzke57201@hotmail.com

AOCO

American Osteopathic College of Ophthalmology
Jacques L. Surer Jr., DO



As the first quarter of our year closes, I trust you all had a good summer. I spent three days in Chicago, attending the first Maintenance of Certification Review Course given by the

American Academy of Ophthalmology. It was interesting to see how they are approaching the test. There is a core ophthalmology section and then there are multiple practice emphasis areas. Study guides for each section are available, and if it is not in the study guide, it will not be on the test. An online set of review questions is also available for feedback.

Our congratulations to Wayne Bizer, DO on receiving the Achievement Award by the American Academy of Ophthalmology. We are very proud of him.

A revised resident surgical log has been completed, and thanks to Dr. Paul Burk this will be available online and keep a cumulative record making review easier.

The Nominating Committee is working on a slate of officers based on our new bylaws, which the AOA approved in July. The Fundraising Committee is hard at work trying to top last year's efforts.

Thanks to all who supported the Mid-Year Seminar in Philadelphia.

Jacques L. Surer Jr., DO
AOCO President
717-843-7829
Fax 717-854-7718
Email: jlseye@blazenet.net

EXECUTIVE VP REPORT

Alvin D. Dubin, DO



There are many exciting things happening that touch the heart and soul of our Colleges, I choose to discuss one of them with you at this time.

At our recent Mid-Year Seminar in Philadelphia (9/6/06), we were pleased to have a Strategic Planning Meeting for the College Boards, conducted by Hershey Bell, MD. Dr. Bell is a Senior Fellow of the Borealis Institute, and is an outstanding Leader in such discussion groups.

It has been two years since our retreat was held, and our Boards believed that it was time to continue in our pursuit of achieving a better level of understanding – ourselves, our College Mission, and our Leadership responsibilities for our Colleges. It was time to re-think not only our Mission, but indeed our Vision, as well.

The undertaking of such a job is not only a big responsibility but also a difficult job. Those involved come from diverse backgrounds, with different Board experiences, and really with insufficient time to fully explore all of the issues that might be involved. All of which leads to this project being done in several stages during the year.

Those that are undertaking this task will be rewarded, and that reward will be in knowing that their work will result in giving our Colleges a strong, and secure future, for our Members.

The discussion lead by Dr. Bell brought up many questions; such as “What do you believe the AOCOO-HNS aspires to be? What will be the legacy of the AOCOO-HNS? And, based on this vision, what are the large scale strategies that you believe the organization should be considering?”

Our current Mission Statement: “The AOCOO-HNS exists to promote the interests of Osteopathic Ophthalmologists, Otolaryngologists/ Facial Plastic Surgeons, to continue to improve their quality of training, education and to advance the practice of osteopathic medicine through a system of quality and cost effective health care measures in the profession.”

This statement was discussed, and Dr. Bell asked the Group to critically review it and determine the “self evident truths” about the AOCOO-HNS that flow from this Mission Statement. Dr. Bell also asked the Group “to consider yourself and your development as an effective Board Member. Do you possess the knowledge, skills and attitudes necessary to assure that the AOCOO-HNS lives its Mission and achieves its Legacy?”

I have chosen to share a part of the interaction with you at this time, rather than wait until the final report is completed some time next year. My reason is to make you aware that your Leadership is taking nothing for granted in their desire to make our Organization as capable as possible in order to fulfill its responsibilities to all of you. Another aspect of this is to help you understand that you too, one day in the near future, may be assuming the mantle of Leadership. Start preparing now by completing the surveys on pages 15-29 of this newsletter.

Mentoring Program

Michael S. Hauptert, DO

Just a reminder about the mentoring program - students, residents and new attending physicians are encouraged to use this program. The mentoring process can occur through several different methods. Personal meetings if possible, but phone conversations or email correspondence may be equally as effective. Seasoned physicians in our Colleges can be a tremendous resource. Mentors can be utilized for a multitude of medical and business related issues. Contact the College Office if you are interested in being matched up with a mentor. This program can only be successful with willing participation as a mentor by the experienced physicians within our respective Colleges. Please consider being a mentor to the next generation of our profession. This is an excellent opportunity to sustain the continued success and longevity of Osteopathic Ophthalmologists and Otolaryngologists.

Communication Committee Update

Paul E. Burk, DO

CATEGORY ONE: Resident log updates are in the works. We have been working with Dr. Jacques Surer for the Ophthalmology end. A spreadsheet has now been developed that will allow residents to enter their information on a monthly basis and the program will automatically summate for year end totals. The resident logs have been updated to the present CPT code numbers. This will allow new CPT code numbers to be added without having to redo the entire form as a range is included on the new proposed form. This was presented at the Fall meeting.

CATEGORY TWO: Clinical assembly educational program: In working with Dr. Thomas Brandeisky, we have attempted to come out with a four-year plan in order to create a grid pattern for scheduling lectures. The basic idea is to recruit physicians within our College who are authorities on subspecialties who will then assist in determining lecture topics. This should keep our lectures current and maintain a high level of academics, as well as decrease any redundancy in lectures.

CATEGORY THREE: The Communications Committee is also working on a generic resident manual. I would appreciate anyone who has such a manual, please forward it to me—preferably in a computerized format. We are trying to take the specificity of any sites out of the manuals to allow all programs to be able to utilize it. This might be helpful for existing programs, should they find something that would work for them and very helpful for anyone starting a new program.

We are also working toward a two week and a four week medical student outline for what they should accomplish through rotations.

On-Call Pay Position Statement

Frank A. Brettschneider, DO

The following position statement may be useful for members who are negotiating with hospitals or third parties to obtain on-call pay. Our members are able to ignore this if they do not desire on-call pay.

“The American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery believes that patients and communities will have better access to Eyes, Ears, Nose and Throat services when Ophthalmologists and Otolaryngologists are reimbursed for being on-call.”

Sleep Apnea in Kids Cuts Brain Power

Paul E. Burk, DO



Sleep apnea in children can lead to brain cell damage and

lowered intelligence, new research suggests. Brain imaging showed that children with untreated, severe sleep apnea show evidence of injury in the regions of the brain responsible for learning, memory, and complex thought. These children also had lower IQ scores and they scored lower on standardized learning tests than children without the sleep disorder. Further research is being done to determine if treatment will reverse any brain injury because sleep apnea is very treatable in children and if it does cause permanent impairment in [brain] function that makes early treatment all the more important.

A child who snores regularly and also exhibits signs of abnormal daytime sleepiness, irritability, or hyperactivity

may have sleep apnea. Sleep apnea-related behavioral problems are often misdiagnosed as attention deficit hyperactivity disorder (ADHD).

Surgery is the treatment of choice for kids with enlarged tonsils and adenoids, and other treatments are available for those with restricted nighttime breathing due to other causes. These findings highlight the importance of recognizing and treating sleep-disordered breathing in children as soon as possible. Sleep is critical for learning and brain function, so parents should not hesitate to discuss sleep disturbance with their child's pediatrician.

AAO-HNS Press Release Vocal Warm-Up Videos Highlight Observance of 2006 World Voice Day

The Fourth Annual World Voice Day was observed on April 16, 2006. However, in the time period up to that date, voice care professionals across the nation asked the public to access their voice quality and recognize that harmful speaking techniques, alcohol, and tobacco abuse can easily and irrevocably damage the voice. The long term consequences of poor voice care can range from strained vocal chords and chronic hoarseness, to deadly head and neck cancers. In the United States alone there are approximately 7.5 million people who have trouble using their voices.

The U.S. sponsor of this day dedicated to the human voice was the AAO-HNS, who represents many physicians who have pioneered new diagnostic and treatment procedures for the care and treatment of voice problems. These procedures are identified in the form of fact sheets available for the public on the AAO-HNS World Voice Day website at www.entnet.org/news/voiceday.cfm.

New to the AAO-HNS website for the 2006 World Voice Day are seven brief videos, offering tips on how to conduct an appropriate vocal warm-up to start your day. Edie R. Hapner,

PhD, CCC-SLP, Assistant Professor Department of Otolaryngology, Head and Neck Surgery and Director of Speech Pathology-Emory Voice Center in Atlanta, is featured in each video. The topics addressed are:

- **Breath relaxation:** Releases tension often associated in the breathing mechanism that can interfere with effective voice production. Ordinarily, if there is tension when breathing, that tension radiates to the voice box muscles. This segment advises how correct breathing can alleviate that tension.
- **Jaw release:** How pushing in and down from the cheeks to the jaw and massaging the facial muscles reduces tension in the mouth and jaw area during speaking and singing.
- **Lip trills:** Releases lip tension and connects breathing and speaking. Also releases tension in the vocal folds.
- **Tongue trill:** This exercise relaxes the tongue and engages breathing and voice.
- **Two octave scales:** Provides maximum stretch on the vocal folds. Start in a low pitch and gently glide up the scale on a “me” sound.
- **Sirens/Kazoo buzz:** Improves the resonant focus of the sound and continues work with maximal stretch on the vocal folds.
- **Vocal cool down:** After extensive vocal use, gently humming, feeling the focus of the sound on the lips is an excellent way to cool down the voice.



The Voice Warm-up videos with additional information can be accessed at www.entnet.org/news/voiceday_warmup.cfm. In addition to the primer on focal warm-ups, the website offers some basic tips that will assist in preserving your voice.

1. If you smoke, quit NOW and avoid secondhand smoke.
2. Drink plenty of water.
3. Try not to use your voice too long or too loudly. Do not scream or yell.
4. Be careful about talking or singing in noisy environments.
5. Avoid speaking or singing when your voice is injured or hoarse.

6. Avoid substances that dehydrate the body, such as alcohol, and caffeine.
7. Maintain physical fitness and watch your diet, specifically avoid spicy foods or things that give you heartburn.
8. Avoid menthol, eucalyptus and strong mint containing lozenges.
9. Warm up your voice before prolonged or strenuous voice use like teaching or giving speeches.
10. Use a microphone when speaking to large groups, particularly if outdoors.

Congressional Advocacy Day/ AAO Mid-Year Forum

Sidney K. Simonian, DO

ADVOCACY ISSUES:

1. **STOP DRASTIC MEDICARE PHYSICIAN PAY CUTS.** The current schedule for Medicare reimbursement is based on the flawed calculation of the Sustainable Growth Rate (SGR) formula, and would call for an overall decrease in physician reimbursement of 26% over the next 7 years. The Medicare Payment Advisory Commission (MedPAC) recommended to Congress a 2.8% update for Medicare physician payments in 2007. We are urging Congress to support MedPAC's recommendation, but more importantly to throw out the SGR formula and develop a long range fix for physician payment.
2. **A 6% INCREASE IN FUNDING FOR THE NATIONAL EYE INSTITUTE.** This increase amounts to 7 million dollars, to total \$711 million. Argument is made that the discoveries in research from the NEI have resulted in a Medicare cost savings to patients who have benefited. For example, the research on panretinal photocoagulation for proliferative diabetic retinopathy, and vitamin therapy for macular degeneration, has saved sight.
3. **CHILDREN'S ACCESS TO VISION CARE.** H.R. 2328. This bill asks for \$75 million to be available to the

states to screen all children for eye disease, and then use the majority of the funds to care for the 2-5% of children who fail the vision screening. The competing optometric bill asks for \$75 million to offer complete eye exams to preschool children. It is felt by ophthalmology that a complete optometric exam, instead of a vision screening exam, would deplete the funds before ever discovering or treating those in need.

4. **THE ASC PAYMENT MODERNIZATION ACT.** H.R. 4042/S. 1884. These bills address the limitations on the types of procedures that can be performed in an ASC. The list was compiled about 25 years ago. Since then, many more procedures have become safe, and more cost effective if performed in an ASC. It is felt that since ASCs are reimbursed only 75% of the procedure fee that is approved for hospitals, there would be a significant cost savings to Medicare to increase the list of approved procedures. This, of course, would not be good for hospitals that rely on their surgical volume to maintain their bottom line.

RESULTS OF OUR EFFORTS

Feedback from most everyone who visited with his/her representatives was pretty depressing. Though there was much sympathy expressed for the first 3 items, the general response was that things wouldn't change much with the



Republicans in charge. There isn't money to hand over to the NEI, and Children's vision care is pretty much a state issue. The SGR, though flawed, is probably going to be another BandAid fix in 2007, just like it was in 2006. And as previously stated, the hospital organizations are going to fight the ASC bills, as a matter of survival.

MID-YEAR FORUM

Some of the more interesting topics included "Managing the Masses", which reported on the shortage of physicians, especially those who care for the geriatric population, as the first of the Baby Boomers are reaching Senior status. Another mini-symposium concentrated on "Quality in the Future: Improving Quality of Care". Discussion centered on the acquisition of new surgical skills using wet labs, surgical simulation and apprenticeships. The ophthalmic community must develop criteria for quality, and demonstrate quality, especially to CMS. Otherwise, it will be done for us (Pay for Performance).

The closing session addressed the National Consumer League findings on public perception and expectation of eye care in America. I highly encourage you to read this White Paper Report by accessing www.nclnet.org. Refer to the White Paper on Eye Care Providers, National Consumers League, October 2005.

Lastly, speakers for the Surgical Scope Fund (Surgery by Surgeons, etc.) have created a Patient Initiative Task Force to which you can report adverse outcomes from optometric treatment of medical conditions.

CARs (Council Advisory Recommendations)

The process by which recommendations come before the Board of Trustees of the AAO originates in the council meetings. Ideas developed in the Regional Council Meetings are given a numerical designation, and then presented at the Council Meeting Hearing for discussion, prioritizing, and then a vote on whether or not to pass them up to the Board of Trustees for consideration. Ten CARs were presented in this session. Feel free to contact me on the details, but here are the titles:

- 06-01 Physician Collective Bargaining
- 06-02 Reciprocity Guidelines for Cross-Border State Society Membership
- 06-03 Website Design and Content Assistance to States
- 06-04 Co-Management Modifier Monitoring
- 06-05 Scholarships for Optometrists Attending Medical School
- 06-06 Participation Incentives and Rewards
- 06-07 MD/OD Difference Education Campaigns
- 06-08 Academy and State Society

Combined Membership-Revised
06-09 Subspecialty Society Dues for
International Federation of
Ophthalmological Societies
06-10 Oculoplastic Surgery: Definition of
Established Training and Expertise

Personal Comments

The American Academy of Ophthalmology is a very well-run and organized group. They put together tons of materials, and prepped us for our big day on the Hill. In addition, the lecture series, the Mid-Year Forum, was a real eye-opener. Updates on specific state political issues, and in some cases, solutions, were very enlightening. I will bring back many ideas for our Colleges. Most important was the opportunity to acquaint myself with many highly motivated ophthalmologists, who have good ideas. Their collective wisdom, organization, and energy have impressed and motivated me, and given me direction. I strongly encourage all our members to attend this event at least once in their career. I can only report to you, happily, that D.O.s are looked upon with respect, and in fact, we were given special acknowledgement for our donations to OphthPAC, and the Surgical Scope Fund. I can't emphasize enough the importance of CONTRIBUTING TO BOTH THE OPHTHPAC, AND THE SURGICAL SCOPE FUND.

Kristin Reidy, DO, and I are classmates in the Academy's Leadership Development Program. She was nominated from the New Mexico State Ophthalmology Society, and has extensive experience in her state's fight over optometric scope of practice. I would also like to mention a former participant in the LDP, Wonsuck Kim, DO, from Alabama. He continues to advocate for Ophthalmology in his state, and has received special recognition from the AAO for his efforts. I highly encourage all of our members to get involved in any way possible in the advocacy process. There are many degrees of involvement. Please feel free to contact me about them at sksimonian@comcast.net.

Networking Ophthalmic Instruments An integral part of a computerized ophthalmic practice

Brian E. Wind, DO

To make the office more efficient, it is becoming evident that the patient information, including the images, need to be accessible easily from anywhere quickly. This means that the instruments need to be networked and connected to an easy-to-use interface. But integrating instruments, images, and patient records into a seamless, networked system can present more problems than most doctors anticipate.

The first problem is image accessibility. Doctors are always on the move, from offices to exam rooms to laser rooms to remote offices to home—and sometimes out of the country. They need access to images anytime, not just during office hours. Doctors need to access images from a variety of devices—laptops, PDAs, or tablets. Unfortunately, instrument manufacturers don't make this easy to do. Usually, images are available only at the specific instrument, or at review stations outfitted with specialized software or hardware keys.

With most instruments, user interface presents another potential stumbling block. In many cases, instruments are designed with technicians, not doctors, in mind, and their operation is hardly intuitive. As a result, many doctors find it faster to examine film images on a light box or printouts than digital ones on a computer monitor, because so many steps are involved in bringing up the correct files. Complicating matters further is the fact that doctors work with so many types of images—FA, Color, US, OCT, Visual Fields, ICG, Slit Lamp, etc. Each of these types of images is available from multiple vendors. That

means doctors must become proficient at numerous user interfaces just to examine images and make measurements.

There are also issues of reliability and security to consider. Instruments don't offer HIPAA compliance or real-time backup systems. Images must be manually transferred for storage onto CDs or DVDs, and historical data isn't immediately accessible. And instrument makers don't provide automated remote monitoring and diagnosis. That means that, potentially, several days could pass before problems are detected and fixed. What's more, instruments aren't secure from viruses and worms that could shut down systems connected to a network.

Finally, be prepared to encounter problems when integrating with electronic medical records (EMR) - the Holy Grail for those aiming for a paperless medical practice. At present, most instrument makers do not offer seamless integration with EMR vendors. In other words, you could have a state-of-the-art digital imaging instruments, and a latest EMR system, but you still won't be able to accomplish a task as basic as analyzing image of a patient's eye along with the patient's medical records.

Before making the final decision to network the instruments, make sure you choose a vendor who addresses these issues adequately. Any good solution should include the features outlined below:

First and foremost, the key to a seamlessly integrated system lies in patient data validation. Choose a vendor that has a very strong validation and monitoring features that makes sure that right information is associated with a right patient. This involves strong feedback

and monitoring mechanism that constantly checks the data at the point of acquisition all the way to the viewer. The last thing you want is pulling up wrong patient information.

Second most important feature is a user interface that is specifically designed for each image type. The workflow is different for Visual Fields as it is for the FA. Make sure the user interface for each image type is specifically designed so that it takes minimum amount of time to review the images. The user interface



should also reflect how doctors practice medicine, for example, by allowing them to call up and compare images from two different studies—all within seconds. It should also be based on an open architecture that can accommodate emerging analysis tools and new types of images. Any good image management system should be able to handle not just retinal images but any instruments such as Cornea Topographer to anterior segment instruments, from different manufacturers.

Also, browser-based system is recommended. Web browsers allow universal access from anywhere, anytime—regardless of system specifications. This means that images can be viewed from any Web-enabled device—not just from review stations equipped with special hardware and software (which is often the case with solutions offered by instrument companies). It also significantly reduces the amount of support internal IT personnel need to provide, since all maintenance is done on a single server machine located at the hospital or clinic—not on individual workstations.

Careful attention should also be placed on networking issues. Slow connections can be a nightmare, but even on fast networks, large image files can take several minutes to access. Look for a system that employs the latest technology for distributing and accessing images so that, in most cases, images can be viewed within seconds. As an example, some type of a local caching of the images for remote locations is important in making sure that any slow network connection does not adversely impact the speed at which the images are delivered.

In assessing a system's reliability, make sure to look for several key features including a real-time backup system with on-line fault recovery. If anything goes wrong, the system will continue to operate, so doctors won't have to interrupt their work. Choose a solution that offers a disaster-recovery system, with off-site secondary backup. Software should automatically detect faults in the system, and the software provider should offer a service that spots and fixes problems remotely—before internal personnel ever notice any difficulties. And because hardware will also fail at times, any solution should include a service that will replace faulty hardware within hours, not days.

In the age of HIPAA-related privacy

concerns and malicious Internet attacks, system security takes on critical importance. Encryption should be of the highest level to protect against hackers. The company providing the digital integration solution should also provide a firewall or multiple levels of firewalls. In addition, the system should feature several levels of password protection, granting some doctors and personnel higher levels of access than others. Each time the system is accessed, it should record the event, creating an audit trail that makes it easy to track unauthorized usage, as required by HIPAA.

It's also important to choose a system that can be easily integrated with EMR (electronic medical records). There are three ways to integrate the instruments with the EMR systems—database integration, web-based integration, or industry standard HL7 integration. Either the web-based or HL7 integration is recommended. To avoid technical problems often associated with integration efforts, make sure the networking vendor you choose works closely with EMR vendors.

Most importantly, all these solutions should be affordable. They should use low-cost, Web-based technologies such as Webs servers, databases and software that comply with Internet standards, and low-cost storage. Once again, a browser-based system reduces the need to upgrade much of the existing hardware at doctors' offices.

There are vendors that claim to do all these things but have yet to deliver a real solution that has been working in the field for at least a year. Make sure to do your homework in choosing the right vendor to work with. It could be one of the most important decisions you will make in computerizing your office.

The above information was created with the assistance of Ken Lee, President of Anka Systems, Inc., who specializes in ophthalmic equipment integration. Dr. Wind utilizes the Anka System in his office, but has no financial interest in the company.

AAO News Room Many Dangers to Eyes Exist in the Most Ordinary Activities

Mowing the lawn, jump starting a car, cleaning the kitchen—everyday activities that usually happen without a hitch. However, these and many other common chores can come at a price: serious eye injuries and permanent vision loss.

Nearly 2.5 million people suffer eye injuries each year in the United States, and nearly one million people have lost some degree of vision as a result. Most could have been prevented with protective eyewear.

"The most ordinary activities can cause extraordinary damage to the eyes," said AAO clinical correspondent, M. Bowes Hamill, MD.

October is Eye Injury Prevention Month, and the AAO and ophthalmologists around the country urge Americans to protect their eyes when engaged in everyday activities.

Dr. Hamill, associate professor of ophthalmology at Baylor College of Medicine in Houston, offered the following prevention tips for both indoor and outdoor activities:



- In the house: When using household chemicals, read the instructions and labels carefully, work in a well-ventilated area and make sure to point spray nozzles away from you. Many chemicals are extremely hazardous and can permanently destroy the surface of your eyes, resulting in blindness. For this reason, it is very important to use appropriate eye protection (goggles)

to prevent blinding consequences from chemical splashes.

- In the workshop: Think about the work you will be doing and wear protective eyewear to shield your eyes from flying fragments, fumes, dust particles, sparks and splashing chemicals. Many objects can fly into your eyes unexpectedly and cause injury.
- In the garden: Put on protective eyewear before you use a lawnmower, power trimmer or edger and be sure to check for rocks and stones because they can become dangerous projectiles as they shoot from these machines.
- In the workplace: Wear appropriate safety eyewear for your job. Many of the thousands injured each day didn't think they needed eye protection or were wearing eyewear inappropriate for the job.
- In the garage: Battery acid, sparks and debris from damaged or improperly jump-started auto batteries can severely damage your eyes. Learn the proper way to jump-start an automobile, and keep protective goggles in the trunk of your car to use for those emergencies and everyday repairs.

ACCIDENTS HAPPEN

Sometimes even the most conscientious person can injure their eyes. Dr. Hamill said it is imperative to seek medical help immediately in case of injury.

"Injuries such as cuts, chemical burns or foreign bodies stuck in the eye are emergencies," he said. "Don't try to treat these injuries yourself; contact your ophthalmologist or go to the emergency room for help immediately."

Even a seemingly light blow can cause a serious eye injury. If a black eye, pain or visual problem occurs after a blow, contact your ophthalmologist or seek emergency medical help immediately. The same goes for a chemical burn to the eye. Flush the eye with clean water and seek emergency medical treatment immediately, Dr. Hamill said.

"With just a little care and common sense, you can go a long way toward protecting your precious gift of sight," said Dr. Hamill. "It is also important to set a good example for your children. If they see you protecting your eyes, they will learn that it is the right thing to do."

Medical Societies Issue Advisory to Cataract Patients Taking Prostate Medications

The American Society of Cataract and Refractive Surgery (ASCRS), the AAO and the American Urological Association (AUA) advise patients taking certain drugs to treat prostate enlargement to inform their ophthalmologist about these medications before undergoing eye surgery. These drugs can potentially cause complications during cataract surgery. However, preliminary results of a new study found that these patients can still have successful surgery if their surgeon knows they are taking or have taken these drugs and alters the surgical technique.

ADVISORY
Tamsulosin (Flomax®) is the most commonly prescribed drug for prostate

enlargement, or benign prostatic hyperplasia (BPH). By facilitating more complete emptying of the bladder, Flomax decreases the need to urinate during the middle of the night. However, Flomax and other similar systemic drugs called alpha-blockers can potentially cause difficulty during cataract surgery, particularly if the eye surgeon has not been forewarned. For this reason, ASCRS, the AAO and AUA advise patients who are taking or have taken alpha-blocker prostate drugs such as Flomax, to inform their ophthalmologist before surgery. Other drugs in this alpha-blocker class include, terazosin (Hytrin®), doxazosin (Cardura®), and alfuzosin (Uroxatral®). The alpha-blocker drugs are all regarded as being safe and effective for the treatment of urinary symptoms due to prostate enlargement without harming the eyes.

THE EFFECT OF FLOMAX® ON CATARACT SURGERY:

In 2005, David F. Chang, MD, and John R. Campbell, MD, completed both a retrospective and a prospective study of 1,600 patients and identified a new

problem that occurs during cataract surgery in patients using Flomax. They called the condition Intraoperative Floppy Iris Syndrome (IFIS).

The iris, the part of the eye that gives it its color, opens and closes in response to varying light levels. Because the iris is located in front of the cataract, the pupil (opening in the iris) must be widely dilated in order to perform the surgery. A large pupil is obtained by using dilating drops that stimulate the iris dilator muscle. Chang and Campbell found that Flomax appears to block this iris muscle, leading to troublesome behavior of the iris during eye surgery. The iris tends to be floppy and the pupil may suddenly constrict during the middle of surgery. If the iris problems are not anticipated or prevented, there is an increased risk of having surgical complications. Interestingly, they still found IFIS in some

patients who had been off the medication for two years. "Flomax does not affect vision or eye health," Dr. Chang said. "But it impairs the dilator muscle in the iris, and during cataract surgery the pupil needs to stay dilated."

Following the publication of Chang and Campbell's findings, and after receiving corroborative reports from other ophthalmologists, the FDA instituted a new label warning for Flomax and other alpha-blocker drugs that reads: "The patient's ophthalmologist should be prepared for possible modifications to their surgical technique." In 2005, frequent discussion among ophthalmic surgeons of problems posed by patients on Flomax resulted in the formation of an ASCRS task force, chaired by Dr. Chang, which developed recommendations for surgical techniques to be used during cataract surgery on patients taking Flomax or other alpha-blockers. The AAO will be including this information in its evidence-based Preferred Practice Pattern® guide (PPPs) for cataract care. These PPP guides are followed by ophthalmologists worldwide.

MULTI-CENTER STUDY OF CATARACT SURGERY IN FLOMAX PATIENTS

To assess the effectiveness of these techniques, a large multi-center trial was undertaken at 10 centers around the country. More than 160 cataract



surgeries were performed on patients taking Flomax using these modified techniques. Dr. Chang reported the preliminary results at a recent ASCRS Annual Symposium in San Francisco. The study demonstrated that if the surgeon knew about the Flomax use in advance, and if the modified surgical techniques were used, the surgical success rate was excellent and the complication rate was not increased in comparison to surgery on non-Flomax patients. Final results of the study will be presented at the AAO meeting in November.

Several important conclusions can be drawn from this study, according to Dr. Chang. "Although the drug can make cataract surgery more difficult, if the surgeon knows in advance that the patient is or has taken Flomax or another alpha-blocker drug, then appropriate techniques can be used that provide excellent results," he said. "Flomax is an excellent prostate medication, and there is no need for patients to avoid it or stop taking it out of concern over eye problems. However, the key is for patients to inform their ophthalmologist when they are taking this or any other prostate drugs prior to eye surgery. This is not something that you would ordinarily think to tell your eye doctor."

BACKGROUND

Cataracts and prostate enlargement are both very common age-related conditions. In men, enlargement of the prostate typically begins around age 55. The condition prevents complete emptying of the bladder, which in turn increases the frequency of urination. Urologists treat prostate enlargement through the use of drugs and, if needed, surgery. Alpha-blockers, such as Flomax, relax muscles in the enlarged prostate in order to improve urinary outflow. This decreases the need to urinate as frequently and allows men to sleep uninterrupted for longer periods.

Cataracts are a progressive clouding of the lens of the eye and are the most common age-related cause of worsening vision. Ophthalmologists treat cataracts by surgically removing the cloudy natural lens and replacing it with a clear artificial lens implant.

AOA NEWS RELEASE

Retail Clinics are Coming - Are You Ready?

Your patients are soon going to be able to choose between seeing you or going to a retail clinic in their local Target, CVS, or Wal-Mart when they are feeling sick. Whether this fast growing trend will bring increased competition or collaboration is unknown but physicians must be prepared.

Retail clinics, also known as store based clinics, are small health centers opening up in high traffic retail stores across the country. Patients can see a nurse practitioner or physician assistant with no appointment. Patients are diagnosed within minutes and are able to fill their prescriptions if needed by the in-store pharmacy. Filling prescriptions at that location is optional but an added convenience that many patients like. If the illness or problem requires being seen by a physician, patients are referred. If the patient does not have a primary care physician, he or she will be referred to one of the clinic's physician referral list.

Most retail clinics accept private insurance. Some even advertise short waiting periods and give patients a pager to allow them to shop while they wait to be treated. There are currently over 150 retail clinics across the country. All provide convenient but limited services such as strep throat, allergies and ear infections. On average most clinics treat 25-40 different medical conditions and charge \$45-75 per visit.

Despite the lack of personal attention by an actual physician, patients like retail clinics because of their low cost and convenience. Clinics are typically open on weekends and in the evening. Most clinics also post their services and costs out in the open for patients and prospective patients to see.

In an ideal world, all patients would go to their personal physician regularly and for every health issue. However, the reality of today's marketplace means that for the immediate future at least some of your patients will utilize retail clinics. Retail clinics must be held

to a limited scope of practice and are governed by state law. It appears this trend is taking off and retail clinics are here to stay. Physicians must adapt and be ready.



Pharmacy

WHAT CAN PHYSICIANS DO?

Get on the clinic's referral list

Physicians must be innovative, collaborative and compete where appropriate and possible. If a retail clinic opens near your office and you are able to accept new patients, call the retail clinics directly and ask to be placed on their referral list. Since retail clinics operate under a limited scope of practice and offer limited services, they keep a referral list of primary and specialty physicians. In addition, if patients agree, retail clinics will send records of the patient's visit to the patient's personal physician. Retail clinics may have their own list of protocols that a physician must follow in order to get on the referral list.

Become a clinic supervisor

Some clinics also contract with a physician to supervise the on site nurse practitioners and to answer calls on an as needed basis. Physicians can call their local retail clinic and apply to become the supervising physician. Each retail clinic will have its own process for selecting a supervisor.

Evaluate and adjust your practice

Many retail clinics are open on weekends and in the evenings and accommodate walk in patients. If a retail clinic has opened near your practice, think about adjusting your office hours to accommodate similar needs. In addition to adjusting your hours, consider adding several walk in slots. Posting your new hours in the waiting room and sending notification letters to all existing patients can also help.

Consider starting your own clinic

Physicians can consider buying their own retail clinic. Start up costs

vary based on geographic location and marketing. Franchise fees can start at approximately \$30,000.

Retail clinics are still new enough that real competition with primary care physicians has not become a widespread problem. However, the health care industry is rapidly moving in this direction. Many patients are likely to utilize retail clinics and it is critical that physicians start thinking about increasing the access and appeal of their practices in order to continue to thrive despite this trend.

Contact your existing patients

Consider sending your existing patients letters encouraging them to make sure you get their medical records if they have gone to a retail clinic. In addition, inform them of your new office hours and increased availability.

The AOA's policy on retail clinics

The American Osteopathic Association has a policy statement on retail clinics and supports that patients be allowed the freedom to choose where prescriptions may be filled. The AOA's policy states that retail clinics adhere to the following principles and standards:

1. Store-based health clinics must establish arrangements by which their health care practitioners have direct access to and supervision by physicians at levels that meet or exceed respective state laws.
2. Store-based health clinics must encourage patients to establish care with a primary care physician to ensure continuity of care. If a patient's conditions or symptoms are beyond the scope of services provided by the clinic, that patient must immediately be referred to an appropriate physician or emergency facility. Also, store-based health clinics should be encouraged to use electronic health records as a means of communicating information with the patient's primary provider and facilitating continuity of care.
3. Whether by electronic communication, or some other acceptable means, store-based health clinics must send detailed information on services provided to the patient's primary care physician in a timely manner to ensure continuity of care.

4. The clinic must have a well-defined and limited scope of clinical services. These services must not exceed the on-site health provider's scope of practice, as determined by state law.
5. Store-based health clinics must use standardized medical protocols developed from evidence-based practice guidelines in their delivery of healthcare.
6. Store-based healthcare clinics must establish sanitary and hygienic guidelines that meet or exceed standards set forth by the United States Department of Labor Occupational Safety and Health Administration (OSHA).
7. Store-based healthcare clinics must conform to privacy and confidentiality requirements as required by the Health Insurance Portability and Accountability Act (HIPAA).
8. Store-based healthcare clinics must conform to all provisions of the Americans with Disabilities Act (ADA).
9. Store-based healthcare clinics must comply with all applicable standards of state and federal regulations expected of physician offices.
10. Store-based healthcare clinics must provide a separate and distinct bathroom for patients and employees within the confines of the clinic.

FOR MORE INFORMATION: Contact Lisa Kaplan, JD at the American Osteopathic Association at 1-800-621-1773 ext. 8194 or lkaplan@osteopathic.org.



AMERICAN OSTEOPATHIC ASSOCIATION

Judge Dismisses Medicaid Law Challenge

Source: Associated Press/AP Online, By Kevin Freking

A federal judge has dismissed a challenge to a law that requires millions of Medicaid beneficiaries to prove their citizenship before obtaining health benefits.



Congress passed legislation earlier this year designed to ensure that only citizens or qualified legal immigrants gain access to Medicaid, which is the state-federal health insurance program for the poor. More than 50 million people get health care through this program.

Several beneficiaries contended in a lawsuit that the new documentation requirements would endanger their health care benefits. However, that contention was nothing more than conjecture, said U.S. District Judge Ronald A. Guzman of the Northern District of Illinois.

Guzman's 21-page ruling was made public Tuesday. He did not rule on the validity of the law. Instead, he said that the plaintiffs made clear their complaint that they were challenging the regulations that the Department of Health and Human Services issued concerning implementation of the law.

But the contested regulations do not create the documentation requirements. They simply flesh them out, the judge noted.

"Absent a showing that their injuries can be traced to the regulations, which they have not made, plaintiffs do not have standing to pursue these claims," Guzman wrote.

Lawyers who are pursuing the case on behalf of Medicaid beneficiaries said they did get a partial victory in the case when the judge said he was likely to issue an injunction that would prevent 500,000 foster children from being subject to the documentation regulations.

"He said there is a strong likelihood of success on the merits for the foster children," said John Mark Bouman, a lawyer at the Sergent Shriver National Center on Poverty Law in Chicago. "If he had also found they were about to be injured tomorrow, he would have entered an injunction. He just wasn't convinced of that part yet."

Bouman also said that one way or another the plaintiffs will pursue the case and ask the judge to rule on the validity of the statute. He described it as an interim ruling saying that children on foster care are likely to win, but with everyone else, there are procedural hurdles to overcome.

In all, 15 people were listed as plaintiffs. Families USA, an advocacy group in Washington, helped organize the lawsuit. Ron Pollack, the organization's executive director, said the documentation requirements are most harmful to victims of natural disasters, the homeless and people with mental and physical disabilities who will have trouble accessing documents such as a passport or birth certificate.

"For many people, this documentation requirement is going to prove to be extraordinarily onerous and many people will be unable to fulfill this requirement," Pollack said.

However, about 8 million Medicaid beneficiaries are also exempted from the documentation requirements, namely elderly and disabled people so poor they qualify for both Medicare and Medicaid, as well as those aged and disabled people who get cash to meet basic needs through Supplemental Security Income.

Congress said that, beginning July 1, documents will be needed to prove identity and citizenship.

Regulations issued by the Department of Health and Human Services say a passport would meet both criteria. A birth certificate would serve as evidence of citizenship, but a second document would be needed to prove identity. In rare cases, sworn affidavits from two citizens can be accepted, but at least one of the two cannot be related to the applicant.

Practicing Physicians Advisory Committee

By Marcelino Oliva, DO, BOFHP Chairman

Paul Martin, DO testified on behalf of the APA at the Practicing Physicians Advisory Council meeting August 28, 2006. Dr. Martin's testimony emphasized the need to change Medicare's current payment formula. He said the AOA supports MedPAC's recommendation that every physician participating in Medicare receives the positive 2.8% update in 2007. In addition, he noted that the AOA has worked with the American College of Surgeons to develop a new payment methodology known as the service category growth rate.

Dr. Martin also gave an overview of the AOA's Clinical Assessment Program (CAP). PPAC member Geraldine O'Shea, DO, asked that PPAC receive an update on CAP's progress at its meeting next year. Dr. Martin also provided AOA's recommended guidelines as the Centers for Medicare and Medicaid Services move forward with quality and pay for performance initiatives.

Prior to Dr. Martin's statement, CMS Administrator Mark McClellan spoke briefly at the meeting. He said input from PPAC and the physician community is very important to the agency. He touched on several subjects such as electronic medical records, physician payment and graduate medical education. Regarding GME volunteer faculty, he said resolving the issue is like putting a "round peg in a very out of shape hole." McClellan hopes the issue will be resolved soon. On removing drugs from the Sustainable Growth Rate (SGR) formula, the administrator said the legal conclusion is there's no obvious way to differentiate between physician services. He noted even if drugs were removed, physicians would still face negative payment updates until 2012. McClellan said moving to a quality-based system would make it easier to address SGR. McClellan wants to work

with physician leadership to get costs down.

Issues discussed at PPAC:

Five-year review/Practice Expense/Fee Schedule: The main topic of discussion was how to apply the budget neutrality adjustment to address the \$4 billion cost to Medicare for revising the work Relative Value Units (RVU) in the five-year review. Many physician associations, including the AOA, have called on CMS to apply budget neutrality to the conversion factor instead of applying it to the work RVUs. Adjusting the Medicare conversion factor would prevent confusion and misinterpretation by other payers who use the Medicare fee schedule to determine physician payments. CMS representatives John Warren and Edith Hambrick explained that the agency's proposal to apply a 10% adjustment to the work RVUs would not change the actual RVU value. The plan is to publish the values without the 10% adjustment and then apply the adjustment internally for Medicare purposes only.



Physicians Regulatory Issues Team (PRIT) Update: Bill Rogers, MD, PRIT director said specialists at CMS are considering proposals to resolve the rules concerning volunteer Graduate Medical Education. He mentioned that several organizations including the AOA have met with CMS administrator Mark McClellan in June about the issue. PPAC members, in particular family practitioner Robert Urata, MD of Alaska, were dissatisfied with the slow pace of resolving the issue. Herb Kuhn, CMS director of Medicare Management, said there are good proposals. The agency wants to maximize training, but it can't violate the law. He hopes to see a resolution within the next few months. Dr. Rogers also clarified Medicare's requirement to have a written request for a consultation. Rogers said consulting physicians are not required to verify that the ordering

physician has documented the request for the consultation. The consulting physician will be paid for the consult and not be penalized. Rogers said the reason for the documentation is to show the consultation was medically necessary. This issue was raised at the AOA House of Delegates in July. Rogers also provided updates on Part D, electronic funds transfer, medically unlikely edits, critical access hospitals, recovery audit contracts and the Part B competitive acquisition program.

Pay for Performance: Thomas Valuck, CMS Medical Officer, updated PPAC members on the agency's efforts to develop quality and efficiency measurements. The agency has asked specialty societies to provide case studies for six clinical conditions. The case studies will be used to test the episode grouper software, which organizes claims data into a set of clinical episodes. The project's objective is to understand the episode grouper technology and its potential uses; to understand the practicing physician's perspectives on episode grouper clinical logic; and understand the kind and quality of adjusted physician resource use reports that episode groupers can produce. The overall goal is to link quality and efficiency measures to assess physician performance. PPAC adopted Dr. O'Shea's recommendation that "CMS should support establishing quality and/or pay for performance initiatives whose primary purpose is to improve health care and health outcomes of the Medicare population. These programs will need additional resources to support implementation and reward those physicians who voluntarily participate. We believe pay for performance should not be budget neutral."

Medically Unlikely Edits: Lisa Zone provided an update on the agency's activities regarding MUEs. The agency adopted PPAC's recommendation to change the name of their program from "medically unbelievable edits" to "medically unlikely edits." CMS plans to have anatomical coding edits in place by January 2007. The comment period for those edits ends Sept. 23rd. Another comment period is planned between October 1-December 1, 2006 for the final phase of coding edits to be implemented in April. CMS will solicit comments through professional organizations and other interested

parties. The agency also will have at least a 60-day comment period prior to any MUE quarterly release. MUEs will be based on data for past periods; clinical judgment of CMS health care professionals; and comments from the health care community. CMS is developing an appeals process for the edits and individual claims. CMS also is considering the use of modifiers.

Other updates were given on electronic prescribing, Medicare pricing for fee-for-service and advantage plans, and outpatient prospective payment system/ambulatory surgical centers.

Prepare for National Provider Identifier (NPI)

By Carol Monaco, AOA, Deputy Director of Regulatory Affairs

"Getting an NPI is free; not having one is costly," is the new slogan to get physicians and other providers to apply for the standard identifier as soon as possible.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates the adoption of a standard unique health identifier to replace provider identifiers currently in use with health plans, including Medicare, Medicaid and all other private and public payers. HIPAA-covered physicians and healthcare providers, whether they are individuals or organizations, must obtain an NPI.

When a physician applies for an NPI, he/she must include all legacy identifiers such as PINs, UPINs, Medicaid number, etc. (To apply, go to <https://nppes.cms.hhs.gov/NPPES/Welcome.do>) However there is more to the NPI than just applying for a number. Without proper preparations, practices may see a disruption in cash flow next year.

A physician practice must contact all of its health plans to determine the plans' NPI implementation timeline. The actual compliance deadline is May 23, 2007 (May 23, 2008 for small health plans). For its part, the Centers for Medicare and Medicaid Services (CMS) released its timeline for using the identifier. CMS currently accepts claims with the NPI, but an existing legacy

Medicare billing number also must be on the claim, otherwise, Medicare will reject it.

According to CMS' tips on NPI, a practice must contact its vendors, business associates and colleagues to see if they are ready to deal with the new identifier and when they will begin accepting it. Office staff also must be trained on using the NPI such as: how and when to disseminate it, how to protect it, and when to collect it from other providers for use in HIPAA standard transactions.

In addition, a practice should develop a plan to ensure that the NPI is kept up to date; plus educate staff on how NPIs from other organizations or peers will be collected and validated for use in HIPAA standard referral transactions. Staff must know what to do if another physician's NPI is needed in a HIPAA standard transaction (i.e., ordered or referred service), but the NPI is unknown.

HIPAA standard transactions include: claims and encounter information, coordination of benefits, claims status inquiries/responses, eligibility inquiries/responses, payment and remittance advices, enrollment/disenrollment in health plans, and referrals.

With less than a year before mandated compliance, CMS plans to hold NPI roundtable discussions via conference calls to help physicians and other providers with the implementation process. CMS suggests that physicians obtain their NPIs at least six months before the compliance deadline to allow time for preparation and testing. NPI products and resources are available through the CMS web site:

www.cms.hhs.gov/NationalProviderStand/.

Medicare Survey Finds Overall Satisfaction in Contractor-Provider Relationship

By Carol Monaco, AOA, Deputy Director of Regulatory Affairs

The vast majority of Medicare health care providers are satisfied with the customer service, claims processing and educational activities provided by the Medicare fee-for-service contractors, according to a new survey conducted by the Centers for Medicare and Medicaid Services (CMS).

The first Medicare Contractor Provider Satisfaction Survey (MCPSS) was designed to garner objective, qualifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The MCPSS revealed that 85% of respondents rated their contractors between 4 and 6 on a 6-point scale.

The survey was sent early this year to more than 25,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. MCPSS will be administered on an annual basis to measure satisfaction with key services performed by the 42 FFS contractors that process and pay more than \$280 billion in Medicare claims each year.

"Our partnerships with physicians and hospitals—the full scope of health providers—is so important that we are measuring their satisfaction with contractors' service levels and hold the contractors to high performance standards," said CMS Administrator Mark B. McClellan, MD, PhD. "The new survey aids us in working with Medicare contractors which, in turn, will help us be more effective in dealing with our providers nationwide."

The survey focused on the seven business functions of the provider-contractor relationship—provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. Respondents were asked to rate their contractors

using a scale of 1 to 6 on each of the business functions, with "1" representing "not at all satisfied" and "6" representing "completely satisfied."

For all contractor types, key predictors for satisfaction were the handling of provider questions and claims processing. The specific composite scores by contractor type are:

- Regional home health intermediaries received an average score of 4.79
- Part A fiscal intermediaries received 4.71
- Part B carriers received 4.52
- Durable medical equipment regional carriers received 4.43

Among those who interact with fiscal intermediary contractors, the most satisfied providers are rural health centers and skilled nursing facilities, both with 4.73, followed by end-stage renal disease treatment facilities with 4.59, and hospitals with 4.57.

For those interacting with carrier contractors, the most satisfied providers are ambulance (4.55) and physicians (4.61), followed by labs (4.50) and licensed practitioners (4.40).

"Provider feedback is a critical component of the evaluation and enhancement process in our effort to get the best possible contractor performance," Dr. McClellan said. "These results from our first-year survey will set the baseline so we may identify trends and address issues in the future. The survey enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to the Medicare program."

In January, the 2007 MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location.

The MCPSS is one of the tools CMS will use to measure provider satisfaction levels, as a result of the Medicare Modernization Act of 2003. It was developed with extensive input from providers, and information about the survey has been disseminated to providers through a variety of channels, including Open Door Forum conference calls with providers, and Medlearn Matters articles posted on the CMS Web site. CMS will conduct ongoing outreach to providers throughout the survey process.

Further information about the MCPSS is available at: www.cms.hhs.gov/MCPSS/.

AOA NEWS RELEASE AOA Re-Releases Statement of Healthcare Policies and Principles to Coincide with Announcement on America's Uninsured Populations

The AOA has re-released its Statement of Health Policies and Principles, adopted by the AOA's House of Delegates meeting in July 2005, to coincide with the Census Bureau announcement that the percent of Americans without health insurance hit 15.9%, or roughly 46.6 million people, in 2005, up from 15.6% of the population in 2004, or about 45.3 million people.

The following statements highlight the osteopathic profession's position on improving access to healthcare for the uninsured population.

- The AOA supports universal health-care coverage in which all Americans have access to healthcare coverage. Coverage can be provided through federal and state programs, private programs, or a combination of the two. Universal coverage should not be confused with a single payer healthcare system.
- The AOA supports the use of the tax code (tax credits and deductions), new purchasing agreements, and the limited expansion of existing federal and/or state programs (including Medicare, Medicaid, and SCHIP) to accomplish this goal.
- The AOA opposes the establishment of a single payer healthcare system in which the federal, state, or local government is the primary source of funding for healthcare services, excluding any existing federal or state programs, such as Medicare, Medicaid, and SCHIP.
- The AOA opposes attempts by the government to mandate healthcare coverage through a defined benefit or defined contribution program.

- The physician-patient relationship must be protected.
- Physicians, in cooperation with their patients, must maintain a high level of autonomy to control the healthcare services provided. Federal policies must not interfere with laws governing patient protections or healthcare rights.
- Policies should support the ability of physicians, hospitals, and other healthcare providers to provide care for patients. Physician compensation for care provided must not be jeopardized by federal, state, or local policies.

The complete Healthcare Policies and Principles statement is available at www.do-online.osteotech.org/pdf/aoa_positiona-f.pdf.

AOA Postdoctoral Update

By Michael I. Opiari, DO, Chair

Dually Accredited Trained D.O.s

The number of osteopathic physicians completing programs approved by both AOA and ACGME between the years 2000—2005 was 545. A data review of these individuals revealed that 80% remained AOA members and 65% held AOA Board certification.

ACGME Statistics

ACGME statistics have revealed a 20% increase in the number of osteopathic residents training in ACGME programs between 2002-2003 and 2005-2006.

Internal Reviews

Policies were approved to help programs with both AOA and ACGME approval to coordinate AOA and ACGME internal reviews. These new standards will permit coordination and eliminate redundancy in combined programs. These newly developed policies will be in effect after the AOA Board of Trustees has approved them in February 2007.

Proposed Plan for Catastrophic Events

The COPT discussed a catastrophic events plan for AOA internships and

residencies in case an unfortunate event occurred resulting in displacement of AOA trainees such as the gulf coast disaster.

This proposal has been sent to the AOA Disaster Relief Committee for comment before going on to the Bureau of Osteopathic Education (BOE) and the AOA Board of Trustees (BOT) for approval.

Disaster Medicine

Discussion took place on the potential development of fellowship training standards in Disaster Medicine for osteopathic physicians in all specialties.

Darrell E. Lovins, DO, Vice Chair of COPT, and a retired naval officer will spearhead this new development.

Core Competencies

All seven AOA Core Competencies are now required to be taught and evaluated in each training program. On site program reviewers are now required to place a greater emphasis on these requirements.

Core competencies are gaining a greater significance in the medical world. They will be utilized for the development and maintenance of licensure and certification.

An emphasis for this activity is being requested of the medical community by third party payors, insurers, credentialing agents, licensing boards and the public.

In addition, residents completing training will be required to have portfolios validating proficiency in all seven competency areas.

91st ACA of the AOCOO-HNS

**May 2-6, 2007
at the
Ritz-Carlton
Sarasota, Florida**

The Ritz-Carlton

A stylish blend of cosmopolitan hotel and beach resort, The Ritz-Carlton, Sarasota is a luxury landmark on Florida's Golf Coast. Conveniently located near the city center, the resort offers guest rooms featuring indulgent

amenities, spacious balconies and sweeping views of Sarasota Bay, the marina or the city skyline.

The Ritz-Carlton, Sarasota offers seven dining and lounge choices including Vernona, where Mediterranean-inspired cuisine



is served in a stylish yet intimate setting. Fashionable Ca d'Zan Bar features signature martinis, the Lobby Lounge serves traditional Afternoon Tea and Bay View Bar & Grill entices guests with uncomplicated fare under the swaying palms on the marina. The Beach Club Grill, located at the Ritz-Carlton Members Beach Club, features a tropical menu enhanced by breathtaking views of the Gulf of Mexico.

The Ritz-Carlton, Sarasota is just minutes away from premier arts venues like the spectacular John and Mable Ringling Museum of Art, nature sanctuaries like the Selby Botanical Gardens, and stylish shopping districts like St. Armands Circle. Preferred tee times are available at award-winning golf courses nearby, and younger guests can enjoy the activities offered by the resort's Ritz Kids® program.

The Ritz-Carlton Members Beach Club, located directly on the Gulf of Mexico on beautiful Lido Key, welcomes guests to an elegant island retreat with a secluded white sand beach, a beachfront pool and poolside dining. Complimentary shuttle service is provided.

About Sarasota

In the Sarasota area, you can enjoy the breathtaking sunsets, educational museums, operas, ballets, plays, golf tournaments, and boat races. You can join in tennis, lawn bowling, water skiing, shell collecting, bird watching, growing exotic tropical plants, university classes, golf, or boating.

The beauty of Sarasota will get your attention on your first visit. If you see Sarasota first from the window of an airplane, the colors of the Gulf of Mexico and Sarasota Bay, contrasting with the brilliant white sand of Longboat, Lido, and Siesta beaches, will make you anxious to see more.

Membership Survey

MAIL BACK TO: AOCOO-HNS
4764 Fishburg Road, Suite F
Huber Heights, OH 45424

OR FAX BACK TO: 937-233-5673



1. Do you see the AOCOO-HNS primarily as an:

- educational group
- professional group
- political group
- social group
- all the above

2. Do you attend your local and regional meetings within your specialty?

- regularly
- sometimes
- never
- none available

3. What is the number of AOCOO-HNS meetings attended in the past five years?

- one
- two
- three
- four
- five
- none

4. What is the number of American Academy meetings attended in the past five years?

- one
- two
- three
- four
- five
- none

5. Do you think that the AOCOO-HNS program content is generally:

- too extensive
- adequate
- inadequate
- not extensive enough
- don't know

6. Do you think that the AOCOO-HNS program content is generally:

- too technical
- adequate
- inadequate
- not technical enough
- don't know

7. Do you think that the AOCOO-HNS program content is generally:

- above your level
- on your level
- on or below your level
- below your level
- don't know

8. Do you think that the AOCOO-HNS program content is generally:

- practical
- not practical
- practical for some
- don't know

9. Do you think more effort should be made to secure more prominent speakers even at a greater expense?

- yes
- no
- not sure

10. Do you think more hours should be offered during the meeting with regular speakers in the morning and taped or video sections in the afternoon to allow a greater number of achievable hours in your specialty?

- yes
- no
- not sure

11. Circle the days of the week that you would prefer for an annual clinical assembly.

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

12. As to time and location, have the past locations suited you?

- yes
- no

13. Have the spring dates suited you?

yes

no

14. Have hotel/resort arrangements been satisfactory?

yes

no

15. Would you attend workshops if given?

yes

no

16. Would you help supervise workshops?

yes

no

17. Which areas would you like more lectures in? Please list:

18. Which past AOCOO-HNS meeting sites have you enjoyed? Please list and explain why:

19. Which past AOCOO-HNS meeting sites did you enjoy least? Please list and explain why:

20. Where would you like to have future sites located?

21. Are the AOCOO-HNS meetings too expensive to attend?

yes

no

22. Would you be interested in seminars in regional locations for additional credit hours and specialty lectures? If so, please suggest first choices of times, dates and day for a two day format.

yes

no

23. Do you feel that our Colleges offer enough credit hours at our annual meeting in your specialty?

yes

no

24. To what extent should the AOCOO-HNS act as an advocate to speak on your behalf?

should have a much stronger voice

should maintain its present level of advocacy

should have less of a voice

25. To what extent should the AOA act as an advocate to speak on your behalf?

should have a much stronger voice

should maintain its present level of advocacy

should have less of a voice

26. If you feel the AOCOO-HNS should have a stronger advocacy voice, which should be the principle voice?

the AOCOO-HNS president or other senior elected officer

a paid lobbyist

government affairs committee chair

members themselves

27. In order for the AOCOO-HNS to have a stronger advocacy voice, would you support an active member dues increase?

yes

no

28. Would you be willing, once every year or two, to meet with Senators or US Representatives to seek their support for an AOCOO-HNS physician on the legislative or regulatory issue?

yes

no

29. What issues should AOCOO-HNS be representing?

30. How helpful do you feel it would be for the AOCOO-HNS to work more strongly at the national level to assist the Osteopathic surgeons in dealing with the managed care networks?

very helpful

somewhat helpful

not helpful

31. Which of the following ways should the Colleges assist you in dealing with managed care? Please check all that apply.

sponsor educational programs

call for legal/technical assistance

lobby Congress

legal action

32. Are you a Fellow?

yes

no

33. If no, do you plan to become a Fellow?

yes

no

34. What suggestions do you have for improving the process for becoming a Fellow?

35. What do you see as the most critical issues facing Osteopathic surgeons during the next three years?

36. How can the AOCOO-HNS help you with these issues?

MINI SURVEY

Dear AOCOO-HNS Member:

In order to attract the best and most rewarding exhibitors to attend our next Annual Clinical Assembly (ACA), we ask that you return the following brief, but helpful survey (please print legibly or return the answers via email).

1. List the approximate total in each category of the 5 most performed surgical procedures.

2. List the approximate total in each category of the 5 most special office procedures.

3. OPHTHALMOLOGY list the 5 most used special testing procedures performed in office and the special equipment used.

4. OTOLARYNGOLOGY list the 5 most used special testing procedures performed in office and the special equipment used.

5. OTOLARYNGOLOGY list the most often performed hearing and related tests, and, equipment used to perform the tests.

6. ALLERGY list the most often used equipment and allergy company used to obtain extracts, etc.

COMMENTS:

FAX BACK TO: 937-233-5673

Name: _____
PLEASE PRINT LEGIBLY

Ophthalmology Opportunities

ARIZONA

- Busy eye group with heavy medical and surgical caseload seeks BE/BC comprehensive ophthalmologist for full/part-time. Fellowships welcome. Competitive salary and benefits package leading to partnership. Contact Craig Cassidy, DO at 480-833-0014 or email: cassidyeyes@aol.com.

KENTUCKY

- Excellent opportunity to join a solo ophthalmologist, desiring to slow down. Opportunity for partnership after one year. Competitive salary and benefit package. Brand new office equipment. New office building. Associate with optometrist. New hospital with state-of-the-art outpatient surgery. Call Dr. Kay Hazelett 606-424-8721.

NEVADA

- Established otolaryngology/ophthalmology practice seeking BC/BE ophthalmologist to compliment group. The practice has three state-of-the-art offices in Henderson and Southwest Las Vegas Valley. All offices are located in community oriented high profile areas with one of the offices adjacent to the Seven Hills Surgery Center and the new Southwest office, located next to the new Southern Hills Hospital. Practice partnership and ASC opportunities available. Contact Judy Duncan at jduncan@nveyepa.com or 702-492-6928.

OHIO

- ENT/Head & Neck Surgeon in NE Ohio. BC/BE required. Active two physician practice with senior partner planning retirement after 36 years. Busy audiology, allergy and hearing components. State of the art facility and active community. If interested in this excellent opportunity, email drgwv@hotmail.com.
- Opportunity in Ohio—small town north of Dayton. General ophthalmology practice with partnership/ownership. Send C.V. and indicate intentions to: Gregory T. Schamaun, DO, 6050 St. Rt. 571 East, Greenville, OH 45331.
- Excellent anterior segment/glaucoma surgeon needed for group practice in Toledo. Salary plus incentive with buy-in after two years. Send C.V. to Ronald M. Kendrick, DO, 5555 Airport Highway, Suite 110, Toledo, OH 43615. Phone: 800-782-9214, FAX 419-865-3451.

PENNSYLVANIA

- Opening in a busy ophthalmology practice. Contact: Jane Kokinakis, DO, office # 800-845-8424.

WEST VIRGINIA

- Glaucoma specialist wanted. Join a team of two ophthalmologists and one optometrist bringing high quality care to Southern West Virginia. Best equipment available. Starting salary up to \$250,000.00. Shape your own practice but surgical opportunities are limited only by your skills. Contact mkrasnow@marshall.edu or call Bettie Chapman at 304-697-0393.

WASHINGTON

- OPH wanted in beautiful Washington State. Opportunity for someone interested in aggressively expanding a practice, or someone interested in working half-time and sharing the practice. A new DO medical school is being built in Yakima. There is opportunity for any level of participation. Hospital owned ASC with all new equipment. Call Dr. Leo Figgs 509-952-8545.

Otolaryngology Opportunities

ALASKA

- ENT wanted. Kenai Peninsula, S.W. of Anchorage. Excellent salary and benefits. Call or email: James Zirul, DO, 220 Spur View Drive, Kenai, AK 99611, call 907-283-5400, email jzirul@acsalaska.net.

ARIZONA

- 320 days of sunshine per year! Become part of a busy, expanding otolaryngology/head and neck/facial plastic surgery practice with full audiology services in the metropolitan Phoenix area. Seeking a BC/BE associate with early partnership opportunity to join our successful team. Competitive salary and benefits. Attractive lifestyle. Please contact Dr. David Mendelson (480) 894-5550 or fax CV to (480) 894-9469 or email to info@entsoa.com.

FLORIDA

- Sunny South Florida, busy solo practitioner seeking associate. Fast-track partnership. Technically advanced offices. EMR/PM, Mini-CAT. Excellent compensation/Bonuses/Benefits. BE/BC. Contact ML 561-963-6313. Email: platinum@bellsouth.net.
- Central Florida Otolaryngology group is recruiting BC/BE otolaryngologist to join rapidly expanding practice. Two clinic sites, Leesburg and The Villages and our main OR site has accreditation from AAAASF. We have four BC ENT physicians, one of which is BC in Facial Plastic & Reconstructive Surgery. We have an Allergy department and complete audiology services with two doctors of audiology and a BC hearing aid specialist on staff plus electronic medical records. We offer good schools with a suburban lifestyle in beautiful Lake County. Excellent salary with partnership anticipated. Contact info: michelle.lakeent@earthlink.net or call 352-728-2404.
- Outstanding opportunity to join very busy otolaryngology/facial plastic surgery practice with partnership track income. Hollywood — Pembroke Pines, Florida. Contact: Dr. Craig Shapiro, 954-437-5333 or fax: 954-437-6252, shap62@aol.com.
- ENT job opportunity located in Ocala, Florida, one hour north of Orlando. Practice is looking for BC/BE general ENT/facial plastic surgeon to join group of 3 general ENT's. Contact Dr. Scott Nadenik, cellular 362-895-0285.

MASSACHUSETTS

- Work in the heart of beautiful New England. Extremely busy practice in North Central Massachusetts seeking associate. Currently one physician doing all aspects of general ENT. Shared call with three others. Community hospitals. This is an excellent opportunity with close proximity to mountains, beaches, and Boston. Contact Dr. Daniel Ervin at (978) 874-7368.

MICHIGAN

- Northwest Michigan practice opportunity. A busy 2 physician practice seeking BC/BE ENT to join practice affiliated with 2 community-based hospitals. For further information contact Andrew Mendians, DO at 231-843-6557 or mendians@voyager.net.

NEVADA

- Established ENT/OPH practice seeking BC/BE otolaryngologist to compliment group. The practice has three state-of-the-art offices in the Henderson and Southwest Las Vegas Valley. All offices are located in community oriented high profile areas with one of the offices adjacent to the Seven Hills Surgery Center and the new Southwest Office, located

next to the new Southern Hills Hospital. Practice partnership and ASC opportunities available. For more information contact Judy Duncan at jduncan@nee-nv.com or 702-492-6928.

NEW JERSEY

- Three man group in Brick, NY has need to add a fourth surgeon. Practice all aspects of Allergy, Pediatric ENT, Hearing and Balance. Call is currently 1:3. Located on the Jersey Shore, one hour from Philadelphia. Apply by letter to: Thomas E. Brandeisky, DO, 208 Jack Martin Blvd., Building C., Brick, NJ 08725 or call 732-458-8575.

NEW MEXICO

- Second BE/BC general otolaryngologist needed for rural practice area in Carlsbad, New Mexico. Mild climate year round in high desert country with nearby mountains and endless outdoor activities. Guaranteed compensation the first year with incentive bonus. Triad owned community hospital. For more information contact Fred Woody, CEO at Carlsbad Medical Center, 505-887-4570.

OHIO

- Seeking an otolaryngologist for position/ownership in an established practice located in Troy, OH. The practice has a well established patient base in Otolaryngology, Allergy and Facial Plastics. The practice has been in this location 20+ years. If interested, please contact Deborah or Georgia at 937-335-7278 or fax to 937-335-1783.
- ENT BC/BE needed in Newark, OH, 30 minutes east of Columbus. Need an additional solo practice physician, 167 hospital undergoing continual upgrading. Additional information can be obtained by calling Michael Ehler at 740-788-6010.

PENNSYLVANIA

- Busy otolaryngology practice in greater Philadelphia area looking for associate with partnership potential. Excellent compensation and benefit package. Contact: Dr. Ben Chack, 301 Oxford Valley Road, Suite 201A, Yardley, PA 19067, phone (215) 321-6666.
- Excellent job opportunity in Chester County, minutes from Philadelphia. Very busy 3 physician ENT practice seeking an additional BC/BE otolaryngologist to join our practice. Unbelievable opportunity for early partnership. Contact Alex Keszei, DO, at 484-437-8745.

TEXAS

- ENT practice opportunity in Corpus Christi. Large group, full practice with speech, audio, balance center, C.T. MRI and surgery center. Need two ENT and one neuro-otologist. Contact Troy Creamean, DO at 361-854-7000.

WASHINGTON

- Practice opportunity in the beautiful northwest. Seeking associate in general ENT and proficiency/interest in FPS, otology and allergy desirable. Contact: Palmer Wright, DO, 3999 Englewood Ave. #201, Yakima, WA 98902, 509-453-5300 or email palmer@yvn.com.

Otolaryngology Fellowships

NEW YORK

- Pediatric otolaryngology fellowship starting 2004, 2005, 2006 at the Women & Children's Hospital of Buffalo. Exceptional opportunity for a 1 or 2-year fellowship covering all aspects of pediatric otolaryngology including complex otolaryngology, cochlear implantation, treatment of vascular birthmarks, laser surgery, airway management, maxillofacial trauma, facial plastics and sinus surgery. Clinical and basic science research is encouraged. Practice has five fellowship-trained pediatric otolaryngologists. Address inquiries to Philomena Behar, MD, email: pmbehar@aol.com.