

Frequently Asked Questions: Otolaryngology

Question	Answer
Case Logs	
When a total thyroidectomy is done, the parathyroid is usually explored and sometimes removed. The question is if the parathyroid is explored or examined, but then not removed; can this procedure be counted as a parathyroidectomy?	I believe it should not be coded as such. Parathyroids are commonly seen in a thyroidectomy, but the parathyroidectomy code assumes the proper workup has been accomplished pre-operatively and that the approach is primarily for parathyroid removal. Otherwise, almost every thyroidectomy could utilize the parathyroidectomy code.
PIF Supplement 2 Institutional Operative Data. Includes data on procedures done by residents and faculty. Is this ONLY those cases performed by both or may it also include cases performed by faculty only?	It is both as the RRC wants to review the total number of cases from the Otolaryngology service.
Our residents go to Guatemala for two weeks during the PGY-4 year. Can we count the operative procedures done in Guatemala or any out of country rotation?	The RRC will not accept operative procedures done out of the country for the following reasons. There is no mechanism for assurance of appropriate pre and postoperative care that may include pre and post hospital continuity of care. In addition there may be inadequate supervision as well as the inability to comply with the appropriate duty hour regulations and the working environment. There is no assurance of appropriate mechanisms to evaluate the residents by the attending and no mechanism for the residents to evaluate the experience. Typically, there would not be an affiliation agreement with routine assurance that the conditions related to resident support, benefits and insurance are in compliance with the Institutional Requirements.
How should the residents code for procedures that include two major components, such as tympanoplasty with ossicular reconstruction?	For example, to get credit for both the tympanoplasty and the ossicular reconstruction, the resident will need to enter the CPT code twice in the System. Even though the code description may indicate that the procedure was both components, because the Review Committee has split them out into two different categories, the resident must enter the code twice to get proper credit. If the resident is doing just a mastoidectomy, he or she should enter mastoidectomy. If resident does only a tympanoplasty, he or she should just enter tympanoplasty. If the procedure includes an ossicular reconstruction, tympanoplasty and mastoidectomy, then the resident enters the CPT three times.

Question	Answer
<p>CPT codes are bundled codes. Yet the RRC is asking for unbundling of codes for coding purposes only. Will you explain this area further?</p>	<p>There are bundled CPT codes for operative procedures, for example, that include, for example, both a tympanoplasty and mastoidectomy. While these are the correct codes for billing, the Committee has determined that they want the residents to unbundle these codes and enter separate codes for example, tympanoplasty and mastoidectomy for recording of operative data in ADS.</p>
<p>With the new category of "resident supervisor" are those who mark this code given as much "credit" as those who are listed as "resident surgeon"?</p>	<p>No. The RRC is interested primarily in the number of cases done as surgeon and assistant. The program requirements call for a progressive experience for all residents and the RRC looks for evidence that the program is meeting this requirement. The role of resident surgeon is important for the Chief year and evidence of the residents' competency to supervise others is a necessary component of resident education.</p>
<p>Is it possible to count the number of cases the resident does in the first year of the residency education and enter them in the case log system?</p>	<p>Yes, residents can count and record the number of <u>otolaryngology</u> procedures only during the first year. The resident can choose to keep a record of all procedures but for the purposes of the Committee, only the otolaryngology procedures should be entered into the data system.</p>
Duty Hours	
<p>What are examples of defined tasks for which PGY-1 residents may be supervised indirectly and examples of defined tasks that PGY-1 residents should have direct supervision until competency is demonstrated?</p> <p><i>[Program Requirement: VI.D.5.a).(1)]</i></p>	<p>Indirect supervision is allowed for:</p> <ol style="list-style-type: none"> a. Patient Management Competencies <ol style="list-style-type: none"> 1. evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests 2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests 3. evaluation and management of post-operative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy 4. transfer of patients between hospital units or hospitals 5. discharge of patients from the hospital 6. interpretation of laboratory results b. Procedural Competencies <ol style="list-style-type: none"> 1. carry-out of basic venous access procedures, including establishing intravenous access 2. placement and removal of nasogastric tubes and Foley catheters 3. arterial puncture for blood gases

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	<p>Direct supervision is required until competency is demonstrated for:</p> <ol style="list-style-type: none"> a. Patient Management Competencies <ol style="list-style-type: none"> 1. initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required) 2. evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes 3. evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy 4. management of patients in cardiac arrest (ACLS required) b. Procedural Competencies <ol style="list-style-type: none"> 1. carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation 2. repair of surgical incisions of the skin and soft tissues 3. repair of skin and soft tissue lacerations 4. excision of lesions of the skin and subcutaneous tissues 5. tube thoracostomy 6. paracentesis 7. joint aspiration 8. advanced airway management <ol style="list-style-type: none"> a. endotracheal intubation b. tracheostomy

Question	Answer
<p>What skills should members of the caregiver team have and how should these be ensured across the team?</p> <p><i>[Program Requirement: VI.E.]</i></p>	<p>All members of the caregiver team should be provided instruction in:</p> <ol style="list-style-type: none"> 1. recognition of and sensitivity to the experience and competency of other team members; 2. time management; 3. prioritization of tasks as the dynamics of a patient's needs change; 4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. compliance with work hours limits imposed at the various levels of education; and, 8. team development.

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