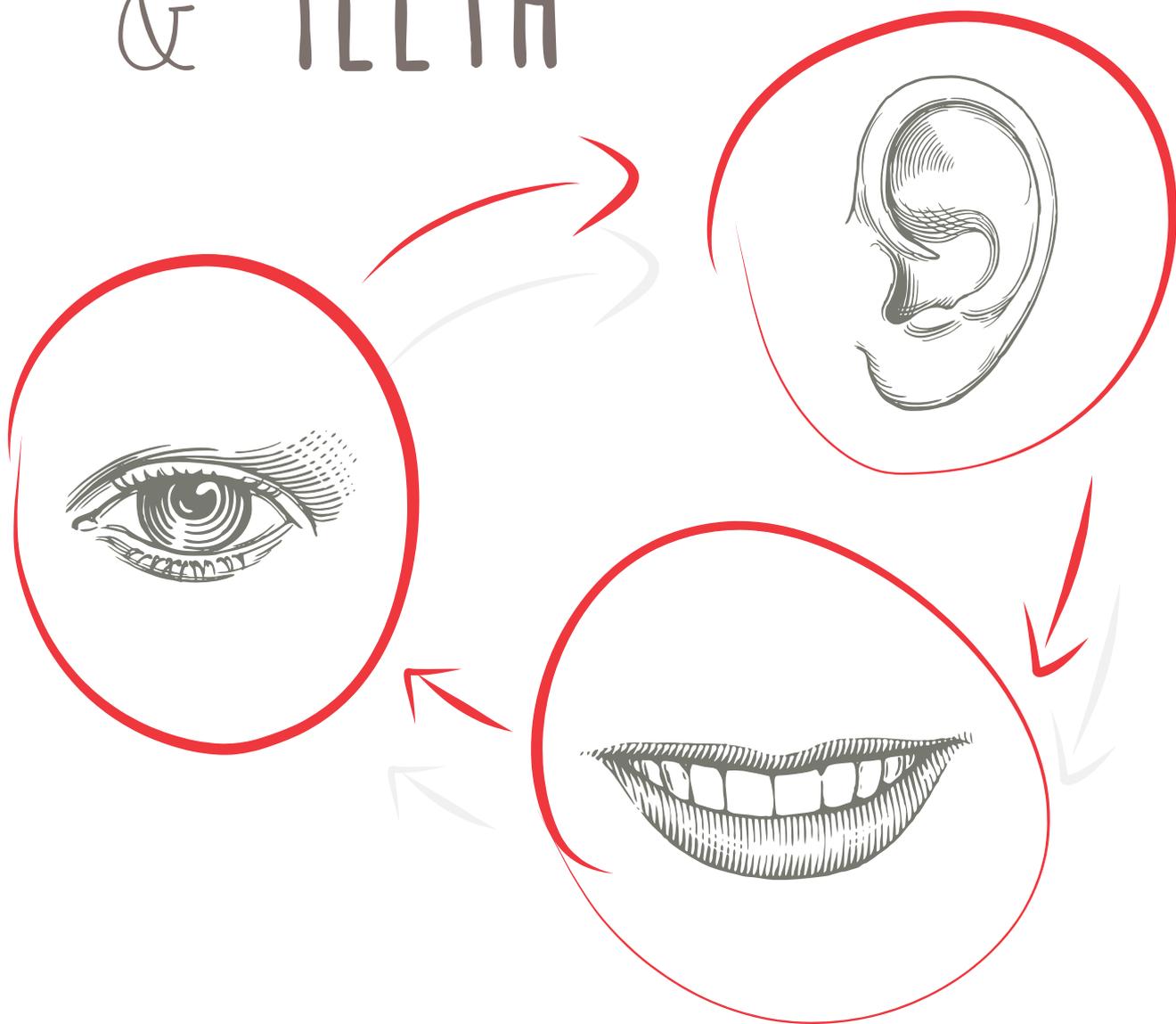


EYES, EARS, & TEETH



BY CHRISTOPHER SPANKOVICH

IS THE BEST PATH JUST TO FOCUS ON WHAT WE DO, TRY TO ESTABLISH LLP STATUS, PROTECT OUR SCOPE OF PRACTICE, AND HOPE TO EXPAND OUR CODE SET TO INCLUDE THE FULL-SCOPE OF AUDIOLOGICAL PRACTICE?



In the March/April 2018 issue of *Audiology Today*, I compared the professions of audiology and optometry and examined some of the successes of optometry in establishing autonomy and an expanded scope of practice. You may want to stop here and give it a read. I'll wait.

Glad you came back.

If you haven't read it yet: The primary takeaway was that optometry has been around longer as a licensed profession (1901 vs. 1969), has its own entry and national board exams, has three times more practitioners, has a larger private-practice presence (57 percent vs. 21 percent), has obtained limited license physician (LLP) status (circa 1986), and has limited prescription rights and surgical rights (defined at the state level). Optometry has faced—and continues to

face—disruptive innovations but, as a profession, it has been able to be the disruptor more often than the disrupted.

I ended that article with the question: “Will audiology be the disruptor or the disrupted?”

In general, disruption offers a trend for simplification to disrupt complexity. Disruption tends to have an upward trend, where a simpler, more accessible service disrupts a higher, more complex service. For example, consider hearing aid dispensers seeking to expand their services into the audiology scope of practice.

Another example, of course, is optometry expanding its scope of practice and disrupting ophthalmology. The optician as a disruptor of optometry is comparable to the disruption of audiology by hearing aid dispensers. In some recent successes

“

for opticians in Canada, opticians licensed to practice in British Columbia are allowed to conduct independent sight tests and determine prescriptions (Collier, 2010).

YOU PROBABLY WENT INTO AUDIOLOGY, AT LEAST IN SOME PART, DUE TO THE FACT THAT THE AUDITORY SYSTEM IS SO COMPLICATED AND THERE IS SO MUCH WE STILL HAVE TO LEARN. IT IS SUPER COOL, RIGHT?

”

WHERE CAN AUDIOLOGY BE THE DISRUPTOR?

Well, if we follow the path of optometry, that would be with LLP status, prescription rights, and surgical services, though not necessarily in that order (Optometry first obtained prescription rights in the state of Rhode Island in 1971, long before LLP status in 1986). Unfortunately, we have barriers—and I am not referring to internal dysfunction and physician opposition.

Surgical Barriers

You probably went into audiology, at least in some part, due to the fact that the auditory system is so complicated

and there is so much we still have to learn. It is super cool, right?

Well, the critical structures also happen to be embedded in the temporal bone. Unlike the more peripheral structures of the eye, the middle ear and inner ear are not easily accessible. Therefore, in most cases, surgeries of the ear are fairly invasive procedures compared to the refractive surgery (Lasik) under the scope of practice in a few states (Oklahoma, Louisiana, Kentucky) for optometrists.

Now, there are less invasive procedures of the ear such as myringotomy, tube placement, and perhaps minor tympanoplasty. The majority of these procedures are geared toward pediatric populations and require sedation. The need for myringotomy in adult populations without the need for sedation is limited. In general, these procedures are used to treat a medical pathology and not necessarily to treat hearing loss.

How about surgeries for hearing loss? Well, if you have ever observed a cochlear implant surgery, you understand the procedure is a very invasive skull-based surgery. We can skip that one for now.

How about other implants, such as middle-ear implants or bone-conduction implants? Middle-ear implants are still invasive procedures requiring the opening of the mastoid. Bone-conduction implants may be more reasonable, a fairly simple procedure, but they require sedation—and, again, are a fairly rare procedure to treat hearing loss.

According to Cochlear (in response to an e-mail), there were approximately 8,200 bone-anchored surgeries in the United States and Canada, combined, in the past year. The advent of non-surgical options for bone-conduction systems may diminish the need for surgical approaches even further—a positive for audiology.

Beyond the limited accessibility of the middle and inner ear is the

comfort of the professional in performing more invasive procedures. There are many audiologists that do not feel comfortable even performing cerumen management.

When it comes to surgery, currently, the invasiveness of procedures in general, the population with the greatest need (pediatric), and the limited need in the spectrum of hearing loss (more than 90 percent of hearing loss is sensorineural) limit our expansion into these practices.

Perhaps non-surgical procedures such as cerumen management (already in our scope of practice) and procedures with slightly greater invasiveness, such as technologies comparable to the Earlens, may be solely under the scope of the audiologist, may not require an otolaryngologist's involvement, and may be reimbursable by insurance.

Pharmaceutical Barriers

Optometrists have limited prescription rights in all 50 states. The breadth of prescription rights varies state by state.

These privileges can include topical antibiotics, topical anti-viral, topical steroids, topical anti-allergy, short-term oral antibiotics, oral antihistamines (non-steroidal), and short-term oral analgesics. The systemic effects of these drugs are fairly limited and, due to the peripheral and visible nature of the pathology, often easily addressed. Optometry prescription rights started with topical agents (i.e., eye drops).

Back to the ear! External otitis, the most analogous pathology to an eye infection, does not commonly create hearing loss, except in the most severe of cases.

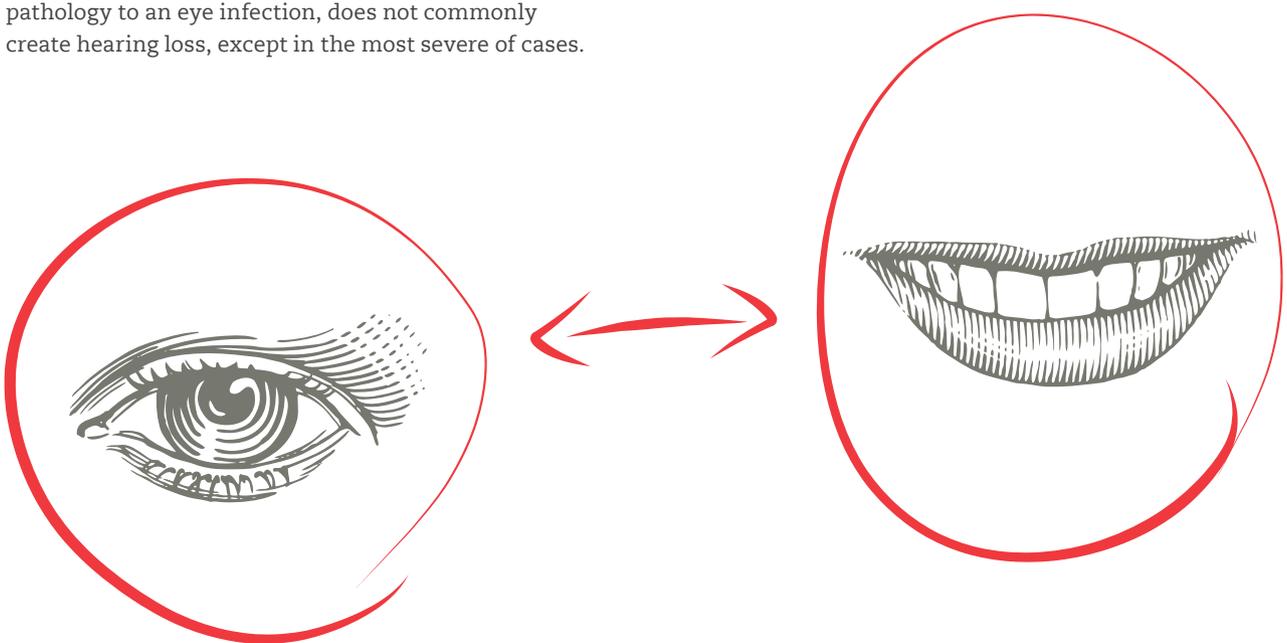
Ninety-eight percent of cases are bacterial in nature and the majority occur in pediatric populations (CDC, 2011).

External otitis is most often treated with topical antibiotics, but systemic antimicrobials are not uncommon (Collier et al, 2013). Otitis media (OM), however, can be more difficult to identify and may be present with co-morbidities. More than 90 percent of OM resolves spontaneously without medical intervention (Marchant and Collison, 1987).

The use of antibiotics as the primary treatment for OM is losing traction, with greater emphasis on the wait-and-see approach (Rettig and Tunkel, 2014). Again, we are limited by the system we work in and the demographics of the most susceptible population. In other words, children are more likely to have ear infections and they are likely to see their pediatrician or an ENT before going to an audiologist.

Other events, such as sudden hearing loss, are audiologic/otologic emergencies and should receive prompt medical attention. Audiologists should retain a diagnostic role in that process. Expansion to ordering labs may be plausible, but would likely require a change in our professional status (e.g., LLP). The current treatment for sudden hearing loss commonly is oral steroids, which even optometrists do not have access to in most states.

Limited prescription rights for the treatment of external otitis or otitis media is plausible, but again is restricted by the population characteristics (primarily pediatric) and the movement to restrict the use of



Sonic Boom

5 Digital Strategies to Boost Your Audiology Practice in Baby Boomer Markets

BY NICK FITZGERALD



ADVERTISEMENT

Over the last 20 years, the Internet has undeniably changed the face of commerce – and that includes marketing. Until recently, the hearing health industry has been insulated from this shift, perhaps due to the assumption of a resistant market. However, Baby Boomers have proven to be a tech-savvy generation, and it's time for us to catch up!

Activate Your Local Market

If there's one thing we know, Baby Boomers have longer attention spans than their younger counterparts and want to see substance. Producing rich, local content about what you do and how you do it in your community will help you get more local eyeballs. Original and fresh content is best, as it will garner more interest and help your rankings with search engines. Use your substantive content on your

Update Your Website

Think of your website as the first impression you give to prospective clients. It is the heart of any online marketing effort. Your website's appearance influences your legitimacy to visitors and will determine if they are interested in doing business with you. Additionally, an outdated website – both in design and content – reduces your search engine rankings. With an updated website, Baby Boomers are more likely to see your practice, which increases the likelihood that they'll become a new patient.

Reallocate Your Marketing Budget

More than 80% of consumers use computers, phones, or tablets to access content. ¹Direct mail and the Yellow Pages are becoming increasingly obsolete. Consider investing that marketing budget predominantly to digital advertising on Google and/or Facebook. Advertising is never inexpensive, but your dollar stretches much further with digital marketing than it would with a direct mail

Get on Facebook and YouTube

According to a recent study by Statista², 68% of Baby Boomers use YouTube and 65% use Facebook (Pinterest trails in third place at 26%). If you want to get in front of Baby Boomers on a social network, use Facebook. If you have the time to produce original video content, get on both networks. Create business profiles for both networks and

stay active on them with consistent updates. When you reallocate your marketing budget, consider advertising on both networks increase your activity and followers/subscribers.

Claim Your Local Profiles for Free

Google My Business and Bing Places are two very important free accounts that will significantly increase your exposure on the search engines. These profiles determine your exposure on location-based searches and maps when people search for terms related to your practice in your area. If you haven't yet, claim these accounts as soon as you can!

In the hearing health industry, Baby Boomers are a tech-savvy market that must be activated, and these five steps are a great place to start. As the marketing landscape continues to evolve, increasing your digital presence is essential to reaching prospective patients.

¹<https://www.smartinsights.com/mobile-marketing/mobile-marketing-analytics/mobile-marketing-statistics/>

²<https://www.statista.com/statistics/436417/us-baby-boomer-selected-social-networks/>

antibiotics in general. Further, though otitis media can commonly create conductive hearing loss, external otitis is less likely to do so. Perhaps the prevention of hearing loss is our ticket.

Currently, there are numerous agents undergoing clinical trial for the prevention of acquired hearing loss. The majority of these agents primarily have an antioxidant mechanism and limited potential adverse side effects. These drugs initially will require a prescription, and this may be a pathway for audiologists to pursue limited prescription rights. This will likely need to start at the state level.

EYES OR TEETH?

Well, maybe I was wrong and perhaps optometry is not the profession we should emulate.

Maybe the answer was near the tip of my tongue the whole time. That's right—teeth!

Dentistry has existed in the United States as a profession separate from medicine since the colonial days. The first school of dentistry was founded in 1840 in Baltimore, Maryland.

The founders of the school (Chapin Harris and Horace Hayden) approached physicians at the College of Medicine at the University of Maryland in Baltimore with the idea of adding dental instruction to the curriculum. However, as the story goes, the physicians rejected the proposal and suggested the subject of dentistry was of little consequence.

Since that time, medical and dental education have remained in separate schools. There have been attempts over the years for a merger, but **dentists, in general, have preferred their professional autonomy over recognition by physicians as an important health-care provider.**

As we are all aware, we have separate dental insurance and there commonly is no dental care in an

emergency room. Also, dentistry has its own separate coding system.

That's right. Dentists do not use current procedural terminology (CPT) codes; they use current dental terminology (CDT) codes. Dental services generally are not covered by Medicare, unless part of another Medicare-covered procedure (e.g., tooth extraction due to jaw-related neoplastic disease).

This also means that dentistry controls its own value.

MAYBE THE TREATMENT OF INFECTIONS IS NOT OUR BEST COURSE. PERHAPS, THE PREVENTION OF HEARING LOSS IS OUR TICKET.

PROCEDURE CODES AND DECISION-MAKING

Currently, as audiologists, we use CPT codes.

In 1983, the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) adopted the American Medical Association (AMA) CPT code system to report services. AMA first developed CPT codes in 1966.

When Medicare transitioned to a physician payment system based on resource-based relative value scales in 1992, the AMA formulated a multi-physician specialty committee known today as the Relative Value Update Committee (RUC). The RUC provides recommendations to CMS about

Medicare payments, though the final decisions are ultimately determined by CMS.

In other words, the AMA has significant oversight on all procedural codes used and proposed to CMS and on the value assigned to those codes. The voices of non-physician groups (including optometry) are represented by the Health Care Professionals Advisory Committee (HCPAC). The HCPAC includes optometry, psychology, physical therapy, nursing, chiropractic medicine, podiatry, social work, dietetics, physician assistance, occupational therapy, speech-language pathology (SLP), and audiology.



CAN AUDIOLOGY BE THE DISRUPTOR?



Audiology achieved a separate seat from SLP only as recently as 2011, a major victory for the profession.

These 12 non-MD/DO professions are represented by only one seat at the CPT and RUC panel meetings. The remaining seats (about 29 of them) are all representative of medical sub-specialties.

BACK TO DISRUPTION

So, what does all of this mean for disruption? That's what we're talking about here, right?

Is our best path to disrupt otolar-yngology, comparable to optometry's disruption of ophthalmology?

Well, the ears and eyes are very different—and substantial obstacles exist for both surgical and pharmaceutical scopes of practice.

Is the best path just to focus on what we do, try to establish LLP status, protect our scope of practice, and hope to expand our code set to include the full-scope of audiological practice (E & M codes, rehabilitation codes, etc.)?

The limitation of this approach is that LLP status does not guarantee access to expanded codes (scope of practice is defined at the state level) and does not change the value of current codes. Another concern is that physicians (in general) oppose LLP status and also have significant control over the CPT code value process as we move forward.

Does the benefit of LLP status outweigh the risk of animosity? Some of you are screaming "Yes" and others are unsure.

Is it possible to separate ourselves from Medicare (by the way, we already sort of are) and separate ourselves from CPT and try to establish our own system, as dentistry has done?

How about Current Audiologic Terminology (CAT) codes?



CONCLUSION

Though there are many lessons to be learned from the field of optometry, we must be cognizant of the barriers to a path of expanded scope of practice related to the differences in the hearing and visual systems.

Dentistry has a nice thing going, in general works outside of Medicare, and its value is not defined by other health professionals. Dentistry also has the advantage of a long-established historical presence as a separate entity from medicine.

The existing role of audiology within CMS (though limited to diagnostic services when referred by a physician) makes separation difficult.

Can audiology be the disruptor?

Perhaps we need to disrupt ourselves by securing our scope of practice at the state level, being recognized and reimbursed for that full scope by CMS, owning our academic programs with audiology-specific entry and exit exams, reaching consensus on a long-term vision for the profession, moving to true board-certification opportunities, and establishing our role in otoprotective therapeutics and novel non-surgical treatments. 

Christopher Spankovich, AuD, PhD, MPH, is an associate professor, vice chair of research, and clinical audiologist at the University of Mississippi in Jackson, Mississippi. He is also an associate editor for Audiology Today and www.audiology.org.

References

CDC. (2011) Estimated burden of acute otitis externa—United States, 2003–2007. *MMWR Morb Mort Wkly Rep* 60(19):605–609.

Collier R. (2010) New eyewear regulations draw ire of optometrists. *CMAJ* 182(9):E407–408.

Collier SA. (2013) Antimicrobial and analgesic prescribing patterns for acute otitis externa, 2004–2010. *Otolaryngol Head Neck Surg* 148(1):128–34.

Marchant CD, Collison LM. (1987) Serous and recurrent otitis media. Pharmacological or surgical management. *Drugs* 34(6):695–701.

Rettig E, Tunkel DE. (2014) Contemporary concepts in management of acute otitis media in children. *Otolaryngol Clin North Am* 47(5):651–672.



“JUNO® has everything we need in a single unit. It’s installation-free, offers outstanding sound quality and coverage, provides easy integration with PFM systems, and — most important to us — enables easy lesson capture.”

— Stephanie Childers, AuD., CCC-A
Mississippi Bend (Iowa) Area Education Agency Leadership Committee

FrontRow JUNO has all the portability, sound quality, and PFM transparency you expect in any classroom sound system. But it’s much more.

Digital feedback suppression is built in.

It’s a media hub, so students can benefit from audio from voice, media, and even emergency announcements.

And it makes lesson capture — MP4 videos of lesson content shown in class plus audio from mics and media — completely painless. For students with special learning needs, that ability to review material can be critical.

For a free trial or just a chat about how we can help, visit **gofrontrow.com**.

gofrontrow.com/at-juno

