Commentary

Brief Commentary on Gidley et al: “Contemporary Opinions on Intraoperative Facial Nerve Monitoring”

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Abstract

Intraoperative facial nerve monitoring (IOFNM) has evolved from requiring sophisticated electromyography equipment to a self-contained monitor with an auditory signal. Subspecialty ear surgeons currently use IOFNM in most otologic and temporal bone procedures as it improves facial nerve outcomes. Our competency and near-universal adoption of IOFNM notwithstanding, otolaryngologists are rarely reimbursed for this procedure. Subspecialists value this technology as medically necessary and should implore fair reimbursement for their expertise in this procedure that is so vital to patient safety.

Keywords

acoustic neuroma, aural atresia, chronic ear surgery, cochlear implantation, facial nerve monitor, facial nerve stimulator, mastoidectomy, otolaryngology resident education, reimbursement, skull base surgery, stapedectomy, SurveyMonkey.com, tympanoplasty

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Reserve of facial nerve function is paramount in otologic and neurotologic procedures. Facial paralysis results in devastating cosmetic, emotional, functional, and financial consequences. Iatrogenic injury to the facial nerve is second only to hearing loss as the most common reason for litigation following otologic surgery.1 Intraoperative facial nerve monitoring (IOFNM) was demonstrated to improve rates of facial nerve preservation throughout the otologic/neurotologic surgical spectrum from surgery for chronic ear infection to skull base surgery. The lack of reimbursement to surgeons for performing this procedure is incongruent with its import as a tool for patient safety.

IOFNM has been used for nearly 40 years. Early systems utilized conventional electromyographic equipment and required a separate physician or technician to monitor for compound muscle action potentials (CMAPs). Modern intraoperative nerve monitors are user-friendly devices designed for use by the operating surgeon to display and capture CMAPs. They provide an instantaneous auditory signal when a CMAP is triggered. This continuous real-time information also provides instantaneous feedback to the operating surgeon, and the need for a monitoring technician or neurophysiologist is eliminated.

Subspecialty surgeons increasingly embrace the use of IOFNM for otologic and temporal bone surgery, as demonstrated in a recent survey.3 Consensus from the earliest survey of American Neurotology Society and American Otological Society members in 1994 was that IOFNM should be reserved for use during procedures in which the facial nerve was thought to be “at high risk.”4 Comments at that time disparaged routine IOFNM and the surgeons who utilized this tool. The current generation of subspecialty surgeons have widely adopted IOFNM. Program directors now report formal training and documentation of competency on the use of IOFNM for their residents, and the American Board of Otolaryngology now considers IOFNM a core competency. Today’s otolaryngologists have the necessary training, knowledge, and skill to perform IOFNM independently, since modern nerve monitors are designed for surgeon use.

Despite its relevance to patient safety, the economics of IOFNM have been unfavorable to surgeons since 2011, when the Centers for Medicare and Medicaid Services (CMS) rule changes precluded the billing of IOFNM by the operating physician. Under CMS, IOFNM is reimbursed when performed by (1) a physician not performing the surgical procedure; (2) a trained and certified audiologist; (3) a certified and trained physical therapist; or (4) a neurologist, physiatrist, or neurophysiologist. Through telemedicine, monitoring may even be performed remotely by a monitoring service, and the simultaneous monitoring of multiple cases is allowed.

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As private insurance companies trend toward CMS rules, few surgeons now submit bills for performing IOFNM, and even fewer surgeons are reimbursed for this medically necessary service. That CMS does not reimburse the otolaryngologist—the specialist of the facial nerve and the individual medicolegally responsible for the facial nerve outcome—is an injustice to our specialty. It is the surgeon who interprets the data and must correlate the data with surgical findings to remove disease and maintain facial nerve integrity regardless of the presence or absence of a nonsurgeon monitor. Reimbursement for IOFNM belongs in otolaryngology, as the liability for facial nerve outcomes ultimately falls to the surgeon. The notion that an operating surgeon is incapable of devoting adequate attention to monitoring while performing surgery is discordant with allowing remote monitoring by a second party who is monitoring multiple simultaneous procedures.

The American Academy of Otolaryngology—Head and Neck Surgery and our subspecialty organizations should engage in discussions with CMS to implement a fair reimbursement for IOFNM for the operating surgeon. A reasonable reimbursement rate for the surgeon’s time and expertise is potentially cost-saving to CMS when compared with the money spent on nonsurgeon monitoring.

Fair reimbursement for this procedure by the operating surgeon is occurring in a few markets. Reimbursement can be achieved by negotiating carve-outs with local HMOs, practice ownership of the facial nerve monitor, and separately dictated procedure reports for IOFNM. Meeting with one’s local CMS carrier to discuss the importance of IOFNM and compare the cost of reasonable surgeon reimbursement with that of a monitoring company can also be successful. Individual surgeons, group practices, and academic departments should all demand payment for IOFNM by private insurance companies and appeal nonpayments to medical directors. Writing off this revenue devalues our service and harms our specialty.

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Jennifer Maw, interpretation of the data, drafting the work, final approval, accountability for all aspects of the work; Paul W. Gidley, interpretation of the data, drafting the work, final approval, accountability for all aspects of the work.

Disclosures
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