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A Publication of the American Academy of Dermatology | Association
Navigating Practice, Policy, and Patient Care

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August is already upon us.

I never quite understand where the summer goes. It seems like the flowers begin blooming and, suddenly, the leaves already start to change colors. Don’t get me wrong, I love autumn. I spent too many years in Vermont not to appreciate that glorious season, but summer is, well, summer. While some of you are sweltering with high temperatures and humid nights, it’s still hard to beat the long hours of sunlight, the amazing fresh fruits and vegetables, and the lack of snow to plow! In case you need more to like about August, here are a few additional reasons to celebrate the month: August is Psoriasis Awareness Month, so perhaps this would be a good time to share your knowledge of all the fabulous new treatments available with your local news media. It’s also National Wellness Month, encouraging us to take care of ourselves, Family Fun Month, and National Golf Month (offering an excuse to play another round!). And if none of these resonate, August is National Goat Cheese Month. Some of you are hopefully enjoying last-minute vacations before scrambling to get the back-to-school shopping done. As you are encouraging (forcing, bribing — you fill in the verb) the kids to complete their summer assigned reading, I hope you will spend a few minutes enjoying my favorite summertime read: this month’s article from the editor.

Those of you who are parents will not be surprised to learn that August is also National Back to School Month. Some of you are hopefully enjoying last-minute vacations before scrambling to get the back-to-school shopping done. As you are encouraging (forcing, bribing — you fill in the verb) the kids to complete their summer assigned reading, I hope you will spend a few minutes enjoying my favorite summertime read: this month’s article from the editor.

This month is a big one for me as I, like many of you, will be sending off my child to college for the first time. He and his close friends recently took a road trip to celebrate their graduation from our Editorial Advisory Workgroup in What’s Hot. For those of you who are parents will not be surprised to learn that August is also National Back to School Month. Some of you are hopefully enjoying last-minute vacations before scrambling to get the back-to-school shopping done. As you are encouraging (forcing, bribing — you fill in the verb) the kids to complete their summer assigned reading, I hope you will spend a few minutes enjoying my favorite summertime read: this month’s article from the editor.

I can only hope that someday, he will understand that to a dermatologist mom, that little bottle of sunscreen is probably a familiar, and hopefully forgivable, Mom nag. I can only hope that someday, he will understand that to a dermatologist mom, that little bottle of sunscreen is really love.
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Apply today for an AAD Young Investigator Award.

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It’s time for a CLIA refresher!

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Learn more about tropical diseases, in an environment where they’re commonly treated, and interact with physicians and other health care professionals who have experience in diagnosis and management of tropical diseases. You’ll also get the opportunity to interact with live patients demonstrating tropical diseases that are seldom seen in the developing world.

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This course will be held at the Regional Dermatology Training Centre (RDTC) at the Kilimanjaro Christian Medical Centre. Educational sessions will take place on Saturday, January 11 and Monday, January 13. Optional tours/activities have been arranged for Sunday, January 12.
In this monthly column, members of the Dermatology World Editorial Advisory Workgroup identify exciting news from across the specialty.

### What's hot?

**Deepti Gupta, MD**

Sinecatechins ointment is a green tea derivative that has been approved for the treatment of anogenital verrucae (AV) in immunocompetent adults and has been reported to be effective in treating extragenital verrucae as well. Sinecatechins has been looked at for treatment of warts in children with both anogenital and extragenital verrucae and found in a case series to have 66.7% (16/24) partial resolution and decreased size of warts and 16.7% (4/24) of patients with complete resolution of warts with median treatment duration of 4.5 months (Pediatric Dermatology. 2019; 36: 121–124). Adverse side effects were limited to mild local irritation in 30% of patients.

Recently, an article in Pediatric Dermatology compared sinecatechins 15% ointment applied BID to imiquimod 5% cream applied three times a week for AV in children (https://doi.org/10.1111/pde.13881). Both imiquimod 5% cream (24% complete response, 29% partial response, 49% no response) and sinecatechins 15% ointment (56% complete response, 33% partial response, 11% no response) showed a moderate effect, but there was a greater effectiveness with sinecatechins with 89% of children experiencing complete or partial resolution of AV. Combination therapy with one or more of the following therapies: podophyllin, cimetidine, candida antigen injections, and HPV vaccine, did not significantly increase effectiveness of topical therapies. Treatment with imiquimod and sinecatechins together also did not show greater effect. Average duration of therapy was 3.6 months in the sinecatechins group and 3.2 months with imiquimod. **Sinecatechins may be an effective and tolerable topical treatment option for AV in children.**

**Edward W. Cowen, MD, MHSc**

In a recent study published in the *Journal of the American Medical Association*, investigators at the U.S. Food and Drug Administration administered four topical sunscreens (avobenzone, oxybenzone, octocrylene, and ecamsule) in different preparations (spray, lotion, and cream) to 75% body surface area of healthy volunteers four times a day for four days (maximal use conditions). Regardless of the sunscreen or preparation, all participants in the study had detectable plasma levels of sunscreen above 0.5 ng/ml within one day of sunscreen use (doi:10.1001/jama.2019.5586).

This report has already garnered significant media attention. However, **it is important that patients understand that this study did not reveal evidence of harm from sunscreen absorption. Rather, it demonstrated that the plasma level of sunscreens under these study conditions exceeded the maximum level (0.5 ng/ml) which the FDA allows for waiver of nonclinical toxicology studies** (e.g., systemic carcinogenicity studies). This threshold level is somewhat arbitrary, and — as the authors note — it approximates the level of potential carcinogenic risk of an unknown compound that would be <1:100,000 in a single dose. Indeed, the concluding statement of the paper is “these results do not indicate that individuals should refrain from the use of sunscreen.”

Nonetheless, in light of this report, patients will likely ask for specific guidance on topical sunscreen use. It is clear that more work needs to be done to understand the risk of sunscreen absorption. Patients should also understand that the plasma levels reached in this study were under maximal application conditions and study participants were not exposed to heat, sunlight, or other environmental factors. Lastly, titanium and zinc oxide were not evaluated in this study, but both mineral compounds are considered by the FDA to be generally safe and effective.

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**Academy sunscreen resources**

Check out the Academy’s patient education resources at [www.aad.org/sunscreen](http://www.aad.org/sunscreen).
Does the current health care business model rely on exploiting the professionalism and inherent dedication of physicians and nurses? That is the issue addressed in a recent op-ed article in the New York Times by Danielle Offri (www.nytimes.com/2019/06/08/opinion/sunday/hospitals-doctors-nurses-burnout.html). According to the article, physicians make the choice to put patient care first — often at personal cost to themselves. One example is that you are at your child’s recital and an elderly patient’s son needs to speak to you urgently. This is not an unfamiliar scenario, and it is why we went into medicine: to help others. Is that professionalism being manipulated in the new era of corporate medicine? As the electronic health record has become standard, some physicians spend two hours of typing for every hour of patient care. The author postulates that if 30% more work was added to a factory line without new resources, it would grind to a halt. It asks us to imagine lawyers doing 30% more work for no more pay. For doctors, not finishing the loop of taking care of patients and charting is unthinkable. Also, the article outlines a staggering statistic that the number of health care administrators increased 3200% from 1975 to 2010. Is that the best allocation of limited health care funds? Is the one endless resource the willingness of medical staff to do the right thing? This article provokes thinking about this subject, especially in the context of rising levels of physician burnout.

The FDA is asking industry for more safety data to determine two things: to what extent skin absorbs sunscreen ingredients, and whether absorbing sunscreen has any effects on the body.

Historically, topical treatments were believed to not result in clinically relevant systemic drug absorption. Over time, with the advances in analytical methods and the recognition of systemic absorption of topically applied OTC products, the FDA started to request pharmacokinetic (PK) trials under maximal-use conditions. For any topical product developed under the New Drug Application process, this information is now a required part of the systemic safety evaluation.

The FDA is requiring maximal usage trials (MUST) for 12 chemical sunscreen filters to evaluate whether, and the extent to which, they are absorbed into the body. While MUST is not representative of real-world sunscreen use, the FDA explained that if the labeled use is determined to be GRASE (generally recognized as safe and effective), then consumers who use sunscreen in a lower volume would still be using it safely. Additionally, the FDA is requesting animal study models to determine if there are any reproductive and developmental adverse effects and carcinogenicity. Industry is contesting the safety requirements set forth by the FDA, arguing MUST is not representative of real-world use, among several other reasons, and is working to meet with the FDA to discuss the requirements.

Currently, sunscreens with broad-spectrum labels must have a critical wavelength of equal to or greater than 370 nm. The critical wavelength is the wavelength at which the sunscreen allows 10% of the rays to penetrate. The FDA is proposing an additional requirement: For a sunscreen to pass the broad-spectrum test, the sunscreen product must show that it provides a UVA/UV ratio of 0.7 or higher. The testing procedure would stay the same. The FDA would require that all sunscreen products with an SPF 15 or higher meet this revised broad-spectrum test, to ensure that consumers have adequate UVA protection given the increasing evidence of the harmful effects of UVA. If the proposed revised broad-spectrum test is not satisfied, then the product would not be GRASE.

The AADA is focusing on robust communication efforts to ensure Americans understand that sunscreen is safe, and that the public continues to use sunscreen and practice other sun-protective measures. dw
Guidelines for the management of hidradenitis suppurativa

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Clinical Applications column, Physician Editor Kathryn Schwarzenberger, MD, talks with Christopher Sayed, MD, about his recent JAAD article, “North American Clinical Management Guidelines for Hidradenitis Suppurativa.”

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Dr. Schwarzenberger: I have always believed that hidradenitis suppurativa (HS) is one of the most debilitating conditions that we treat. However, there has not been much published in the past to help us best treat it. As such, I very much appreciate the time and effort you and your colleagues put into creating guidelines for the management of this challenging clinical problem. Have we made any advances in our understanding of this condition and, if so, has this knowledge improved our management of HS?

Dr. Sayed: Historically, misconceptions that the disease is primarily related to apocrine glands or infection have led to confusion in the approach to treatment. It is clear now that HS is a chronic inflammatory disease that predominantly affects the follicular unit. We have learned that inflammatory cytokines such as TNF-alpha, IL-1, IL-23, and IL-36 are increased, which matches our understanding of other inflammatory diseases. There also seems to be a role for complement-mediated inflammation that is just starting to be understood and may implicate a role for dysregulated bacterial response mechanisms in driving the disease. Our understanding is improving, but we still have so much to learn compared to many less common and less severe diseases.

Dr. Schwarzenberger: Much like in psoriasis, HS is linked to increased risk of metabolic syndrome, obesity, and even cardiovascular death. In fact, the risk in HS seems to be even higher than it is in psoriasis. While higher rates of obesity, smoking, and metabolic syndrome likely contribute to overall risk, it is clear that the risk is increased even when correcting for these variables. In the end, it is not surprising that the high burden of inflammation in these patients affects more than just the skin. To this effect, the Hidradenitis Suppurativa Foundation is currently developing comprehensive guidelines on HS comorbidities.

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Dr. Sayed: While treatment should be individualized for all patients, can you recommend a reasonable first-line treatment regimen for HS? Do you treat men and women the same?

Dr. Schwarzenberger: While treatment should be individualized for all patients, can you recommend a reasonable first-line treatment regimen for HS? Do you treat men and women the same?

Dr. Sayed: This is such a difficult question because it is all related to the clinical scenario. For some patients with mild disease, intermittent antibiotic therapy with tetracyclines or clindamycin and rifampin in combination is a good starting point, especially if patients are developing new lesions. For female patients, adding combination oral contraceptives and/or spironolactone can also be helpful. For a patient describes one or a few recurrent lesions as opposed to new lesions arising, this may be a good opportunity for limited surgical intervention and minimal medical management, especially in older patients without disease progressing to new areas. A patient with extensive Hurley III disease may need to start with a biologic such as a TNF-inhibitor in addition to antibiotics, and ultimately will likely need surgery for the best long-term results.

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**Q.** Dr. Schwarzenberger: When do you call in the surgeons for help? What really works best?

**Dr. Sayed:** If a patient has limited sinuses that are persistently or recurrently inflamed, then surgical intervention is likely to be necessary. This can often be achieved in the outpatient setting by a dermatologist comfortable with local excisions and deroofing procedures. If a patient cannot tolerate local anesthesia or the disease is too extensive to be excised under local anesthesia, referral to a capable surgeon may be necessary. The best approach for patients with progressive disease will often combine medication to stabilize the disease, and then surgical intervention to address recalcitrant areas. For lesions that have been present fewer than 2-3 months, it is worth trying non-surgical interventions when possible.

**Q.** Dr. Schwarzenberger: Do you have any predictions as to future directions in HS management? Will we still be treating patients 20 years from now the same way we are treating them today?

**Dr. Sayed:** There are several drugs in clinical trials for HS so I will be shocked if new FDA-approved treatments are not readily available 20 years from now. There needs to be a major push to better understand the science behind HS going forward since the approach in most trials now is to investigate drugs that have already been evaluated for psoriasis or other conditions and hope they work in HS too. I am hopeful that a better understanding of HS will lead to drugs that are better suited for this particular disease. Unfortunately, one thing that will likely not change is the need for surgical intervention in some patients. The physical change and scar associated with sinus tracts are unlikely to completely resolve in the short term with medications alone, which is the most challenging part of HS management that distinguishes it from psoriasis and other skin diseases. I am, however, hopeful that more dermatologists will be trained and prepared to offer some level of surgical intervention since so many patients currently struggle to find an adequately trained surgeon when they need one.

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We read with interest a recent Clinical Applications column in *Dermatology World* ([www.aad.org/dw/monthly/2019/june/clinical-applications](www.aad.org/dw/monthly/2019/june/clinical-applications)) on the topic of using gene expression profiling (GEP) to identify risk of melanoma metastasis. The column suggests GEP should move into clinical practice. However, a balanced assessment of risk associated with using the test has not been provided.

GEP is being used in both thick and thin melanomas, the latter of which represent the vast majority diagnosed. Considering GEP a “competing good” belies the potential for significant harm to patients, especially when using this for thin (< 1mm) melanomas. The performance characteristics of this test are mediocre at best, with a positive predictive value of only 10% (*J Am Acad Dermatol*. 2019;80(6):e161-2). In practice, this test could potentially harm 13% of patients by giving an incorrect result. This has the potential to affect thousands of melanoma patients with unnecessary testing, or give certain patients false security.

Issues of tests with significant false positivity are not new in medicine. The U.S. Preventive Services Task Force no longer recommends screening mammograms in patients 40-49 years old because benefits do not outweigh harm (false-positive results, unnecessary biopsies), except in high-risk populations (*Ann Intern Med*. 2016;164(4):279-96). Similarly, GEP requires data transparency, balanced delivery of information, and the incorporation of population-based statistics into guidelines in order to understand who may benefit most from the test.

The column notes that experts in the field “feel” the test should transition into clinical practice. However, these decisions should be guided by evidence-based medicine performed without conflicts of interest. Clarity will emerge from running prospective clinical trials to assess the harms and benefits, rather than simply utilizing the technology in a “larger community” and seeing what “will emerge.” The stakes are too high, and we owe all stakeholders the transparency of data so they can make informed decisions.

*Editor’s note: The Clinical Applications interview in the June issue of Dermatology World included discussion of a Castle Biosciences-funded study on which the interviewee was an investigator. Neither Dr. Leachman nor her department received financial compensation for her participation. Future Clinical Applications articles will include a statement of potential conflicts of interest from authors interviewed.*

Dermatology World welcomes responses to content in the form of submissions to the Other Voices column from members of the American Academy of Dermatology. Submissions should respond directly to content presented in the magazine and are limited to 250 words. DW’s editorial team reserves the right to accept or reject submissions and to edit submissions prior to publication. A response from the editor may be added if applicable. *dw*
Don’t miss this month’s Insights!

In the latest commentaries, Dr. Heymann and the Dermatology World Insights & Inquiries editorial board address topics including:

- Eosinophilic dermatosis of hematologic malignancy: Reality bites
- A metabolic pathway that may allow dermatologists to run rings around porokeratoses
- Schnitzler syndrome: The continuing search for an optimal biomarker
- Putting muscle into isotretinoin laboratory testing isn’t chopped liver!

Look for DW Insights & Inquiries every Wednesday in DW Weekly, or go online to www.aad.org/dw/dw-insights-and-inquiries to read the latest and search the archives.
DISASTER STRIKES. ARE YOU PREPARED?

Experts offer advice on emergency preparedness planning.
“We went through hell after Hurricane Katrina. It was pandemonium. Talk about getting caught without any plan in a situation that turned out to be catastrophic.” New Orleans dermatologist Patricia Farris, MD, learned about preparedness the hard way.

Hurricanes. Floods. Fires. Tornadoes. Earthquakes. These are just a handful of natural disasters that can destroy everything in the blink of an eye. From the Camp Fire — the deadliest wildfire in California’s history — to Hurricane Michael — one of the strongest Atlantic hurricanes since 1969 — 2018 was an unprecedented year in the amount and severity of natural disasters. Disasters like these have underscored the need for physicians to prepare for the unthinkable.

A 2018 national survey from Healthcare Ready found that for a third year in a row, the potential for natural disasters tops the list for threats that cause the most concern among Americans — more than terrorist attacks, cyber attacks, and disease outbreaks. Despite concerns about natural disasters, more than half of Americans do not have any emergency plan in place.

This month, Dermatology World talks with members about their experiences shepherding their practices through natural disasters, and with health care and legal experts about best practices for protecting your practice and your patients.
Step 1: Assess your risks
Planning and preparing for natural disasters can be overwhelming, especially for small or solo physician practices that may have limited resources. The first step is to perform a risk assessment based on the likelihood of certain disasters occurring in a geographic location, advised Molly Evans, JD, a partner in the health law practice group of D.C.-based law firm Feldesman Tucker Leifer Fidell LLP. If you live in California, you’ll have to account for risks like wildfires, earthquakes, and mudslides; if you live in Kansas, you’d consider tornadoes and other severe weather a risk. In the assessment, physicians should include not only a listing of potential threats, but also note the likelihood of occurrence, impact severity, and current level of preparedness to identify gaps in preparedness and better triage resources toward creating an effective plan.

In September 2016, the Centers for Medicare and Medicaid Services (CMS) published a final rule on emergency preparedness for health care providers that establishes national, consistent emergency preparedness requirements for 17 provider types, including hospitals, participating in Medicare and Medicaid. While most dermatology practices are not subject to the CMS Emergency Preparedness Rule, Evans recommends starting the planning process by reviewing CMS regulations and seeing how they can be scaled to fit individual practices. “The Department of Health and Human Services (HHS) has published many free resources available to anyone. While the HHS resources are geared toward the 17 provider types covered by the rule, the health center templates may be helpful for dermatology practices,” she said. These resources are available at https://asprtracie.hhs.gov.

“The Kaiser Hazard Vulnerability Assessment (a free online tool) is also a useful template to get started,” said Evans. It includes natural disasters as well as other potential threats and hazards, such as epidemics, power outages, and active shooter situations. View the Hazard Vulnerability Analysis tool at https://www.calhospitalprepare.org/hazard-vulnerability-analysis.

Step 2: Ensure records access
One of the most critical aspects of a disaster preparedness plan is ensuring physicians have access to patient records, said Julie Brightwell, JD, RN, director in the Department of Patient Safety and Risk Management at The Doctors Company, the nation’s largest physician-owned medical malpractice insurer. “Physicians need to be able to function without a computer for a period of time.” Many physicians utilize a cloud-based EHR, however, it’s also good practice to have multiple backup methods, with at least one backup stored at an off-site location, she said. Online cloud storage, portable hard drives, flash drives, and remote servers are relatively quick and easy ways to create multiple backups. Regardless of backup method, all formats must keep records private and secure in compliance with HIPAA.

Even if physicians are unable to access their EHR system, they still need to keep a thorough record of care. Some EHR vendors will provide backup paper records, Brightwell said. For those using paper records, it’s important that they are kept as free from the elements as possible. If records are stored in boxes or bins, make sure the containers are waterproof, stored off the ground, and kept free from food and drink to avoid vermin. If patient records have been lost or destroyed, the physician will have to re-create the record to the best of his or her ability while indicating that the new record is a re-creation.

The same holds true for financial records, such as accounting, billing, and tax documents. They should always be accessible in some form no matter your location. Dr. Farris also recommends keeping duplications of important paperwork — such as insurance policies, accounting paperwork, tax documents, human resources, and important contact information — and storing them in a remote site — or two. A certificate of insurance for medical malpractice coverage should also be included, Brightwell said, in case a practice relocation is required.

Expert advice
On Oct. 10, 2018, Hurricane Michael, a Category 5 hurricane, made landfall near Panama City, Florida, where Jon Ward, MD, the founder of Dermatology Specialists, worked to keep the practice operational. Because of his location, Dr. Ward’s practice had a robust plan to ensure access to electronic patient records. “We had an electronic medical records system and a Voice over Internet Protocol (VoIP) phone system, both of which had a main fiber-based internet line and a backup fiber-based line from two separate providers. The thought being if one provider goes down, you just switch to the other.” During the hurricane, both lines failed. Yet, the practice had a plan C, which involved the chief information officer physically removing the servers and driving them to the nearest practice location where he would then reconnect all the offices within the networks that were not affected. Even after successfully executing plan C, it was another 24 hours before the practice was back online, Dr. Ward said.

“Hurricane Michael hit on Wednesday, although we were aware on Tuesday of the potential to encounter serious problems. On Tuesday, management communicated with everyone in the practices to be ready to lose EMR connectivity for the rest of the week,” Dr. Ward said. “Staff printed off schedules and paper encounter forms. We had a plan in place for everyone to be on paper for the rest of the week.”
Step 3: Plan a communication strategy
When disaster strikes, communication with staff and patients is critical for safety and business continuity. Regardless of practice size, all staff should be informed of emergency plans. Dr. Farris keeps a folder that contains the emergency response plans with the responsibilities of staff, and each year at the beginning of hurricane season, she reviews the plan with staff. Physicians should develop a full-circle call tree with home, office, cell phone, and email contact information included. Staff will need to know whether they should come in to work, whether certain procedures are cancelled, or what tasks need to get done if they can work, Brightwell said. Additionally, the plan should include how to get in touch with local and federal emergency response officials, Evans said.

If physicians are in a situation where there is no cell service or electricity, there should be a plan in place for how to alert staff and patients, such as using instant messaging technology, social media, patient portals, practice website updates, or taglines on the news. There are also apps (like FireChat) available that allow people to connect without Wi-Fi or a cellular network.

Patients must also be contacted. If the disaster allows adequate warning, print upcoming patient schedules and contact information for the next week or so and make a list of which patients are waiting on diagnostic tests.

“Step 4: Don’t skimp on insurance
It may be tempting to save on mounting costs by shopping around for cheaper insurance. If you find that you are able to swap plans and save money, ask your agent what coverage you’re sacrificing. Know exactly what your policy covers and what it does not cover. Ask questions based on the risks you may face, Brightwell recommended. If you live along the Gulf Coast, you’ll want to know whether you’re covered for hurricane damage. If you live in California, you’ll want to make sure you have wildfire and earthquake protection. One of the easiest things physicians can do to prepare for disasters is to call their insurance agent and learn about their coverage. “Thoroughly researching your insurance policies will be critical, especially for solo physicians and smaller practices,” Dr. Ward said.

Business interruption policy
When asked what dermatologists should do to prepare for a natural disaster, Dr. Farris unequivocally responded: Make sure you have business interruption insurance, which is designed to cover lost income when a business is temporarily closed because of events beyond the business’s control. A typical business interruption policy can provide coverage for the profits you would have earned, normal operating expenses, and the expense of moving to a temporary location. Insurance payouts are based on records of business income and expenses, so have these records in at least one other location off-site.

“You’ve got all the overhead because rent doesn’t stop, malpractice doesn’t stop, all your insurance policies are still in effect — nothing stops except business income. That’s where business interruption insurance really comes into play.”

“After Katrina, I happened to be in the office assessing the damage and my landline rang. It was a lady, who had evacuated to Florida, calling to find out about the results of her biopsy. After searching, I found her report in the office undamaged, and sure enough that patient had a melanoma. Had she not called me, I don’t know if I could have found her. There was no finding anybody at that point. It was like you were in the Twilight Zone.”

“Expert advice
For Dr. Ward, social media was the primary way his practice communicated with patients. “Facebook was probably the most instrumental social media source for everyone.” Since the primary cellular service provider was down, everyone used burner phones on alternate networks for the next few months, he said.

After Hurricane Katrina, cell service was down, and the mail had stopped. This was before Dr. Farris had implemented an EHR system, so she was unable to communicate with her patients. “After Katrina, I happened to be in the office assessing the damage and my landline rang. It was a lady, who had evacuated to Florida, calling to find out about the results of her biopsy. After searching, I found her report in the office undamaged, and sure enough that patient had a melanoma. Had she not called me, I don’t know if I could have ever found her. There was no finding anybody at that point. It was like you were in the Twilight Zone.”
timely manner. They assume everything that you’re telling them or asking them to do is fraud. And they delay,” he said.

Business interruption insurance also helps cover staff salaries. Staff may be living paycheck to paycheck, especially if their lives were impacted by the disaster. If they can’t be paid, they’ll leave, and when things finally return to normal, the practice will be unable to function, Dr. Ward said.

Step 5: Mind your dollars and cents
Even with solid insurance protection, having liquid income at hand is essential. “Every dermatology practice should have a line of credit set up in advance — even if you never draw upon it. Aside from natural disasters, there could be a delay in Medicare payments for a month or something else that may disrupt payment,” Dr. Ward said. Ideally, physicians should have a line of credit for at least six months of after-tax liquid income as a personal contingency.

Unfortunately, dealing with payers during times of disaster is not cut and dry, Evans said. There is no guarantee that payers will waive the rules about timely filing. Often they will if the area is declared an official disaster area. Regardless of the disaster, be sure to contact payers and ask for filing extensions.

Step 6: Keep perishables from perishing
Having a plan to manage perishables can prevent thousands of dollars in losses, Dr. Farris said. During Hurricane Katrina, she lost quite a bit of money on perishable items. If you’ve got perishables like neurotoxins and things that are extremely expensive, you need to take those with you, she said. “You need to decide in advance who is responsible for taking what out of the office,” she said.

If a physician rents office space, they should insist that the landlord provide generators that are regularly maintained. If office space is owned, have generators in an area protected from flooding. Some of Dr. Ward’s practice locations relied on backup generators to protect medications; however, they failed and the practice lost everything. The silver lining: “All of our refrigerated items went bad, but they were covered under our contents policy. We did not have any losses that we weren’t reimbursed for,” he said.

Dermatologists will also need to consider how to safeguard tissue specimens. “We left biopsy specimens in the office, which won’t get damaged in formalin, but if I had a plan in place to take them, I could have sent them to our pathologist who was at a path lab out of town.” Additionally, it’s important to know where samples are in the pipeline. Are specimens awaiting pickup? Are they at the lab? Are results expected soon? If there is an evacuation with some notice, have this information accessible.

Step 7: Search for backup
While not always feasible, a practice may be able to identify an alternate location to practice in the event of an emergency. Check with local hospitals to see whether they may be able to provide a space to see patients, or scout out another building or practice that may have space available to rent. Physicians in larger practices with multiple locations may have an advantage in that some practice locations may expand beyond the disaster zone.
**Expert advice**

Dr. Ward owned an empty commercial building — and this building happened to be in the minority of buildings relatively untarnished by Hurricane Michael. He and his staff were able to use this space to set up a call center and billing station.

**Step 8: Review and testing**

The last piece of the puzzle is planning an annual review of the emergency plan and conducting an emergency response drill at least once per year. Local emergency response teams and the Federal Emergency Management Agency (FEMA) website are often good resources to help practices plan and execute drills.

The least resource-intensive drill is called a tabletop exercise, which is typically held in an informal setting. This type of exercise is intended to generate constructive discussions regarding a hypothetical emergency. Staff participate in talking through scenarios, discussing options, and finding things that have not yet been addressed in the plan.

“What surprised me most is just how vulnerable you really are,” Dr. Farris said. “Something like a natural disaster can completely change everything. Usually, physicians are good at keeping things in order, but something like that can pull the carpet out from beneath your feet financially and emotionally. The amount of loss can be significant,” she said, “so better to be safe than sorry.”

Many disasters — both natural and manmade — have implications for the skin, said Adam Friedman, MD, professor and interim chair of dermatology and director of translational research at George Washington University (GWU) School of Medicine and Health Sciences. In the summer of 2018, Dr. Friedman attended an interdisciplinary leadership course where he met MacGyver — well, someone who could mimic his seemingly magical ability to problem solve using a Swiss Army knife, duct tape, matches, and chewing gum. At the course, he met emergency medicine physician James Phillips, MD, EMT-T, director of the Disaster and Operational Medicine Fellowship at GWU.

“Instantly, I was intrigued and felt like dermatology fits into emergency training. There are generic skin issues that can emerge, such as infections and contact dermatitis from natural disasters. While effects of manmade disasters, like exposure to radiation and certain toxins, also present a unique opportunity for dermatologists to get involved in disaster medicine training.”

Dr. Friedman recalled a survey from the early 2000s that focused on dermatologist responses to bioterrorism. The survey results showed 88% of respondents said they did not feel prepared to respond to an attack while 45% said they wouldn’t even know how to recognize skin findings related to bioterrorism. “Nearly 20 years later, what has changed? Not much. There’s been little focus in this area.”

Dr. Phillips and Dr. Friedman joined forces and created an IRB-approved survey to gauge dermatologists’ comfort level with disaster response — both natural and manmade. The survey inquired about whether dermatologists thought more training is needed, and when they would want to receive that training.

Dr. Friedman was surprised by some of the findings. He assumed most respondents would report having virtually no training in disaster response. However, nearly 30% said they had some degree of disaster response training. Regardless, most physicians still have no training at all, he said.

Additionally, most dermatologists indicated that they wanted the Academy to take an active role in delivering this training through didactics, and live trainings and simulations. “I look at my role as uncovering an unmet need, but I have that same need to learn this information,” Dr. Friedman said. It will require interdisciplinary collaboration to get a training program for dermatologists off the ground. “I think dermatology is poised to play a very big role in disaster medicine.”

Technology-based encounters in dermatology

BY ALEXANDER MILLER, MD

Alexander Miller, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Miller, who is in private practice in Yorba Linda, California, represents the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

Up until January 2019, Medicare limited reimbursement for telehealth medical services to those delivered in Alaska or Hawaii, a rural Health Professional Shortage Area (HPSA), Federally Qualified Health Center (FQHC), or telemedicine demonstration areas. Recognizing the expansion of store-and-forward technology and the value of these services to their beneficiaries, the Centers for Medicare and Medicaid Services (CMS) introduced two new reimbursable G-codes specifying patient to physician/qualified health professional store-and-forward technology-facilitated, and electronically enabled live interaction communications care.

As detailed in last month’s Cracking the Code column, the Current Procedural Terminology (CPT®) contains codes for electronically facilitated interprofessional consultation services, and Medicare reimburses for these services when they are medically reasonable and necessary. CPT code 99441 describes reporting of 5-10 minutes of telephone evaluation and management (E/M) services. However, broader codes specifying store-and-forward (asynchronous) and electronic patient with qualified health professional E/M interactions are absent. In its Final Rule for 2019, CMS introduced a new store-and-forward (asynchronous) care G-code and a live interaction code, both reimbursable by Medicare, as defined below.

G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days, nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

G2012 – Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven days, nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

G2010 may be reported to your Medicare Administrative Contractor (MAC) when you, the physician, or other qualified health care professional (QHP) evaluate information transmitted to you electronically by the patient. This pre-recorded information, consisting of still images or video, must be reviewed, and the patient must be contacted with a follow-up non-face-to-face interaction within 24 business hours after the review. All manner of available electronic follow-up is allowed, including telephone, live audio-video, email, secure text messaging, and secure patient portal. Naturally, both the original image evaluation and the subsequent electronic interaction should be documented in the patient record. Patient consent to the electronic interaction should be obtained and documented.

There are specified qualifications for billing G2010: There should not be a related E/M service within the preceding seven days, and the remote interaction must not result in a subsequent in-person E/M visit or procedure within the following 24 hours “or soonest available appointment.” The latter, for practical purposes, implies that if a procedure or E/M visit ensues consequent to the store-and-

Modifier madness

100 10
01 01
10

Read more about skin biopsy NCCI PTP code pairings at www.aad.org/dw/monthly/2019/april/modifier-madness.
forward interaction, the electronic interaction is not billable. Regarding billing, ensure that your electronic transaction is billed with Place of Service (POS) code 02 – Telehealth, as this specifies the delivery of telehealth services from a remote site.

Medicare defines QHPs who may report/bill for electronic patient interactions as those who are allowed to independently bill Medicare for E/M services, including those listed below (source: MLN booklet, Telehealth Services). State laws governing scope of practice and independent billing will also dictate who would be allowed to bill, and under what circumstances or limitations. For Medicare purposes, the following are considered qualified health care professionals:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists

Example 1

Your established Medicare patient — whom you have not seen face-to-face for two months — sends you electronically transmitted photos of a groin rash. You determine that the images closely resemble a tinea cruris eruption treated by you several months ago. You recommend a topical antifungal agent. Seeing no improvement after two weeks, the patient calls your group practice and schedules the first available appointment with another dermatologist in your group practice. This dermatologist evaluates the patient and prescribes an oral antifungal.

You bill Medicare: G2010 for the initial electronic evaluation

Your associate dermatologist bills: CPT 99212 for the tinea cruris diagnosis and treatment

Answer: Incorrect. Since the patient is seen by another physician of your specialty in your group practice, this would be considered a follow-up visit pursuant to the telehealth evaluation. The subsequent E/M visit would be bundled into the telehealth evaluation and is not separately billable.

Example 2

You evaluate photos of a “suspicious spot” sent to you by your patient. You determine that the lesion may represent an aggressive squamous cell carcinoma and refer your patient to a Mohs surgeon colleague for diagnostic biopsy and potential surgery. The patient makes the first available appointment with the referred dermatologist. You bill Medicare G2010 for your service.
**Answer: Correct.** Although the electronic interaction led to a subsequent E/M visit, that evaluation was done by an independent physician in a different practice from yours. The G2010 definition states that it should not be billed if the electronic evaluation results in a subsequent E/M visit or procedure provided by the same physician, or another physician within the same group practice, who provided the communication technology encounter.

**Example 3**
Your established patient, whom you have last evaluated in-person three weeks ago, sends you an image of a rash, concerned that it may be shingles. The photos, despite excellent autofocus capabilities of the patient’s cell phone camera, are quite blurry. You evaluate the photos, speak directly to the patient by telephone to elicit more information, and recommend that the patient send better photos, as you cannot render a precise recommendation based upon the submitted images. You bill Medicare G2010 for the service.

**Answer: Incorrect.** Since a recommendation beyond that of “send better photos” could not be rendered, a complete electronic evaluation was not done. The service is not billable.

**Example 4**
A patient has a melanoma widely excised from their cheek. Five days later, the patient returns for suture removal, at which time the dermatologic surgeon discusses the pathology results with the patient and schedules a subsequent melanoma surveillance appointment. Three days after, the patient — concerned about a possible infection — sends the surgeon photos of the surgical site. The physician evaluates the photos and determines a diagnosis and plan. As the electronic encounter occurs more than seven days after the surgery, G2010 is billed to Medicare for the telehealth interaction.

**Answer: Incorrect.** Although the telehealth service was done eight days after surgery, there was a subsequent physician interaction with the patient that occurred three days prior to the electronic interaction. This included removing the sutures, evaluating the surgical site, counseling the patient about the excision pathology, and determining an appropriate follow-up visit. Consequently, the electronic encounter is not separately reportable.

**Example 5**
Two weeks after prescribing a topical steroid therapy and skin care regimen for a patient with severe asteatotic eczema, the patient calls the dermatologist using video conferencing to report response to therapy and to ask questions. The QHP obtains and charts a patient consent for the interaction and then immediately activates a timer to track the period spent conversing with the patient. Seven minutes tick by during the interaction, which included discussing response to therapy, answering patient questions, and counseling the patient on further skin care. The service is reported to the MAC with G2012.

**Answer: Correct.** The brief check-in service originated from a previous E/M service done more than seven days prior to the communication technology contact. The patient consented to the interaction. No subsequent face-to-face visit resulted. This electronic encounter is separately billable.

**Example 6**
Your patient calls 10 days after surgery and speaks to your licensed vocational nurse to inquire about healing progress and discuss physician-recommended further postoperative care and follow-up. The interaction takes six minutes. G2012 is billed for the service.

**Answer: Incorrect.** The communication technology-based service was done by a non-physician/QHP. The service provider must be a physician/QHP in order to justify billing G2012.
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Academy takes on scope of practice, access to drugs, and indoor tanning legislation in the states

STATE NEWS ROUNDUP

BY VICTORIA PASKO, MANAGER, STATE POLICY

By August, most state legislatures have gavelled out of session for 2019. However, seven states have year-round sessions, and the American Academy of Dermatology Association (AADA) continues to advocate at the state level on behalf of physicians and patients. Here’s the latest advocacy activity:

Scope of practice

As the workforce expands to include greater use of non-physician clinicians, the AADA works to appropriately define the practice of medicine, advocating for a physician-led, team-based approach to care. The AADA advocates for the adoption or modification of regulations that ensure that structures are in place that focus on the highest level, appropriate care and patient safety. Further, the AADA works to ensure patients have accurate and truthful information regarding the provider’s advertised credentials and board-certification.

The AADA submitted a letter to the Louisiana Senate Committee on Health and Welfare opposing legislation that would remove supervision of physician assistants. The bill was ultimately stripped of all provisions proposing to change the supervisory relationship and retains present laws.

Nebraska has a state scope of practice review process in place that requires any scope expansion to be considered by the Department of Health and Human Services Credentialing Review Program. The physician assistants submitted a request to expand their scope of practice and the AADA submitted a letter opposing physician assistant independent practice and expanded scope.

The AADA joined the American Society for Dermatologic Surgery Association, the American Society for Aesthetic Plastic Surgery, the American Society for Laser Medicine and Surgery, and the American Society for Ophthalmic Plastic and Reconstructive Surgery in opposing legislation in New York that would expand the scope of estheticians to perform laser hair removal and then create “laser hair removal technicians,” defined as licensed estheticians whose practice is limited to laser hair removal.

Planning a state advocacy day?

AADA staff welcomes invitations to participate in meetings and speak to attendees about Academy advocacy. Email Lisa Albany at lalbany@aad.org and Victoria Pasko at vpasko@aad.org.
The AADA and the Alabama Dermatology Society sent a joint letter to the Committee on Education Policy supporting legislation that would ensure transparency of health care provider qualifications by requiring advertisements to be free from deceptive or misleading information and requiring providers to wear credentials stating their type of licensure.

The AADA and the Pennsylvania Academy of Dermatology and Dermatologic Surgery submitted a joint letter to the Senate Appropriations Committee opposing legislation that would authorize independent practice of nurse practitioners.

**Access to pharmaceuticals**

The AADA works in collaboration with all stakeholders to minimize and/or eliminate barriers that patients face in accessing necessary medications.

Legislation mirroring the State Access to Innovative Medicines (SAIM) Coalition’s model step therapy bill was signed by Delaware Gov. John Carney in June. The AADA and Delaware dermatologists supported the bill through letters and testimony. Similar legislation was also signed by Maine Gov. Janet Mills in June. The AADA supported the effort.

The AADA and the New York State Society of Dermatology and Dermatologic Surgery sent a letter to the New York Senate Committee on Insurance supporting legislation that would prohibit insurers from forcing a patient in the middle of the policy year to switch from a covered prescription drug to another medication as a result of an insurer’s decision to remove a covered prescription drug from its list of covered drugs, or reclassify such drug to a more restrictive drug tier, unless there is a generic equivalent or interchangeable biologic. Further, the bill would prohibit a health insurer from adding utilization management restrictions to a prescription drug on a formulary unless the changes occur at the time of enrollment. The bill passed committee.

Take action

Getting involved in advocacy is easier than you think! Check out the AADA’s Advocacy Action Center to learn how you can get involved at https://takeaction.aad.org.
Indoor tanning and skin cancer prevention

The AADA works with policymakers to introduce and support laws, regulations, and resolutions that promote skin cancer prevention and awareness. Twenty-two states now prohibit minors under 19 from using indoor tanning beds.

In May, Maryland Gov. Larry Hogan signed legislation that prohibits minors under 18 from using indoor tanning beds. Jill Allbritton, MD, of the Maryland Dermatologic Society and Academy State Policy Committee deputy chair, AADA staff, and representatives from the American Cancer Society-Cancer Action Network attended the bill-signing ceremony. The Maryland Dermatologic Society received several advocacy grants over the past few years to support this effort. The law goes into effect Oct. 1, 2019.

Legislation prohibiting minors under 18 from using tanning devices was signed by Maine Gov. Janet Mills in June.

The AADA drafted a joint letter, signed by the Illinois Dermatologic Society, Illinois State Medical Society, and the American Society of Dermatologic Surgery Association in support of legislation that would require health plans to cover — without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement upon the insured patient — one annual office visit, using appropriate routine E/M CPT codes or any successor codes, for a whole-body skin examination for lesions suspected as skin cancer. The whole-body skin examination must be indicated using an appropriate International Statistical Classification of Diseases and Related Health Problems code or any successor codes.

The bill as originally written was problematic, requiring coverage for “dermatology examinations,” a vague classification for which there is no billing code. Amy Derick, MD, Academy President George Hruza, MD, MBA, Mark Kaufmann, MD, the Illinois State Medical Society, and AADA staff worked to introduce amended language that would better meet the goal of the legislation, which was to increase access to life-saving skin cancer screenings. Agreeable language was ultimately included in the bill, passed both chambers, and awaits the governor’s signature. dw
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Academy brings skin cancer awareness to Capitol Hill

FEDERAL NEWS ROUNDUP

BY VICTORIA HOUGHTON, MANAGING EDITOR

Dermatology World breaks down the latest highlights of AADA advocacy activities at the federal legislative and regulatory level.

To raise awareness about skin cancer prevention and awareness, the Academy and several other organizations hosted more than 250 congressional staffers and members of the public at its annual Capitol Hill Skin Cancer Prevention Fair and Screening.

The event featured Hall of Fame quarterback Bob Griese, who lead the 1972 Miami Dolphins to the NFL’s only undefeated Super Bowl winning season. Griese spoke with dozens of attendees, signing copies of his recent article in Forbes that described his battle with melanoma, the value of early detection, and the importance of sunscreen use.

Seventeen volunteer, board-certified dermatologists provided 104 skin cancer screenings and consultations for patients — a record number of screenings for the event. Academy President George Hruza, MD, MBA, was joined by Drs. Suraj Venna, Bruce Glassman, Shabnam Shahabadi, Jennifer DeSimone, Cheryl Burgess, Aubrey Wagenseller, Murad Alam, Vesna Petronic-Rosic, Vishal Patel, Liz Robinson, Angelo Landriscina, Matthew Livingood, Aaron Fong, as well as Rep. John Joyce, MD, who screened his congressional colleagues.

New public grassroots advocacy action center

The AADA has launched a new public-facing grassroots advocacy action center. Check out the new Grassroots Action Center at www.aad.org/advocacy/action-center/grassroots-action.
Seventeen volunteer, board-certified dermatologists provided 104 skin cancer screenings and consultations for patients — a record number of screenings for the event.

In addition to congressional staffers, 16 bipartisan members of the House of Representatives participated in the event, including:

- Ami Bera (D-Calif.)
- John Joyce (R-Pa.)
- David Joyce (R-Ohio)
- Ben Cline (R-Va.)
- Glen Grothman (R-Wis.)
- Brett Guthrie (R-Ky.)
- Chuck Fleischmann (R-Tenn.)
- Adrian Smith (R-Neb.)
- Buddy Carter (R-Ga.)
- Steve Watkins (R-Kan.)
- Mike Thompson (D-Calif.)
- Bill Johnson (R-Ohio)
- Jim Hagedorn (R-Minn.)
- Vern Buchanan (R-Fla.)
- Robert Aderholt (R-Ala.)
- Brian Fitzpatrick (R-Pa.)

The Academy was joined by the following partner organizations at the event:

- American College of Mohs Surgery
- American Society for Dermatologic Surgery Association
- American Society for Mohs Surgery
- Dermatology Nurses Association
- Children’s Melanoma Prevention Fund
- Melanoma Research Foundation
- National Council on Skin Cancer Prevention.

Not sure which topics are important to the specialty right now? Review the AADA’s top advocacy priorities at www.aad.org/advocacy/advocacy-priorities.
Digital marketing for dermatologists 101

Use these basics to build the perfect practice website
Why should dermatologists care about how they’re portrayed online? “It’s like the yellow pages of today,” explained Maxim Polansky, MD, a dermatology resident at Emory University School of Medicine. Unlike in the past, professionalism now often begins with first impressions made online, as patients increasingly turn to Google, Siri, and Alexa to help them find a dermatologist. While online reviews undoubtedly play a large role in how patients pick physicians (for better or for worse), the importance of a modern, well-functioning practice website should not be overlooked.

“The website is the first place you can get a sense of the physician, and what the practice is about. It’s just the first taste of who they are, what kind of care they provide,” said Dr. Polansky. “You may think your patients aren’t looking things up, because maybe most of them are in their 70s, but that’s completely not true. They’re just as savvy as younger people when it comes to technology.”

As a result, a good practice website should be a one-stop shop for patients to get information about the practice, find out what insurance they accept, make an appointment, or pay a bill — and give physicians some agency over how they’re portrayed online. In the first of this two-part series on digital marketing for dermatologists, Dermatology World will address:

• Website basics — what you need to know
• How to get your web presence up and running

Next month, keep an eye out for “Digital marketing for dermatologists 102,” for social media marketing best practices. >>
Digital marketing for dermatologists 101

The basics
Does your website check these boxes?

Aesthetic: Photos, color scheme, staff bios — the overall look and feel of your site.

“We often talk about what makes a modern website design — what the word ‘modern’ really means,” said Jason Lindsay, director of marketing at Officite, a digital marketing company for health care providers. Lindsay recommends dermatologists stick to a design that features simple, easy-to-read fonts, uncrowded pages with ample white space, and neutral colors.

Professional photos of physicians and their staff have been shown to increase patient trust, and overall dermatologists should aim for a style that matches the look and feel of their practice. “We have a boutique — primarily cosmetic — practice, and wanted that to be reflected in our branding and website design,” said Faiyaz Kalimullah, MD, a dermatologist in private practice in Chicago. “We asked our marketing company to design the site so it felt, clean, modern, and upscale, but also easy to navigate.”

Location: Where can patients find you — and is your practice correctly listed in search engines?

While dermatologists undoubtedly want to make sure the address listed on their site itself is the correct one to avoid lost (and grumpy) patients, they should also spend the additional effort of making sure they’re listed at the right location across the web as well. Search engines pull from different sources online to not only determine a practice’s location, but also what type of business it is. Correct categorization is key, as an unfortunate hernia surgeon learned in 2016, when he discovered that his unusually low patient base following a recent move was the result of Google mistakenly tagging his new practice as a mobile home dealership.

How did this happen? Search engines like Google pull from different online directories and major websites (think Facebook) to determine a business’s location and type. Inconsistent addresses and phone numbers across the web can create enough mixed messages to confuse search engines and make practice websites exceedingly difficult for new patients to find. Dermatologists can proactively feed correct information to these directories, some of which include Infogroup, Axiom, Factual, Localeze, and Yext, although often there is a fee involved.


“Google’s algorithms look at a variety of different factors to determine search engine rankings, including the amount of cross-linking to the site from other pages, the use of commonly searched keywords in titles and on the pages themselves, geographical proximity, and Google reviews,” said Dr. Kalimullah. “Downtown Chicago is a highly competitive market, and we wanted to ensure that our website performed well in search results.”

Dr. Kalimullah’s practice opted to work with a full-service marketing company to develop its branding, website design, and SEO strategy. “Although this approach required a fairly significant investment on our part, we felt that it ensured a certain degree of continuity in our overall marketing approach to ensure that the page was designed to gradually move up in the rankings,” he said. “Our website also went live more than four months before we actually opened our doors, so our SEO team could gradually help our page move up in the rankings before we had even started scheduling patients.”

Good site security can also assist with search engine performance, said Lindsay. “As of July 2018, Google started ranking secure websites higher than unsecure websites. So, having that SSL certificate, HTTP versus HTTPS — that was part of the change. They started ranking those websites a little bit higher.”

Cyber hacking in health care

Pay-per-click (PPC): Taking a step beyond SEO.

“For a lot of people, the goal is making it onto that first page of search results, and there’s really two ways to get there,” explained Lindsay. “The first is SEO — which takes a bit longer and is something you build over time. The second — which is if you want to get on there tomorrow — is pay-per-click advertising.” While there are different PPC providers, Google AdWords is often the most popular choice due to the massive scope of the search engine.
Picking which search keywords to focus on, however, can be an expensive and time-consuming process without the right insight. “AdWords is a very complicated thing, so that’s often where an agency or company comes into play,” said Lindsay. “A lot of those people are AdWord-certified, so they know which words to rank for, and which words to not rank for. For example, you might want to rank for ‘Botox’ or some other service that a dermatologist provides, but if someone types in the word ‘free,’ you wouldn’t want to be listed.”

Once businesses determine which search keywords they want associated with their listing, they must bid on them in an auction setting. “You’re basically saying I’m willing to pay X number of dollars to show up first, second, or third. Google will then make an algorithm based on that, and it will show your ad according to your bidding strategy,” said Lindsay.

Dermatologists can also strategically utilize PPC advertising to target a specific patient population or geographic area. “The nice thing about Google AdWords is you can run a campaign within a certain radius or zip code,” said Lindsay. “For example, if 90% of your patients come within a five-mile radius of your office, you can set those parameters and get pretty hyper-local targeting to look for new patients that are in-market at the time.”

If you’re just getting started...

Don’t have an established web presence? Follow these steps to get off to the right start.

**Step 1: Create a Google Business listing.**

To avoid search engine issues down the road, dermatologists — even those part of group or academic practice — should create a Google Business listing to help correctly establish their location and allow patients to leave them reviews on the platform. “We have worked very diligently on maintaining our online reputation, and we’re currently one of the highest-rated practices in Chicago on Google Reviews, which has helped our page ranking and has been one of our most important sources of new patient referrals,” said Dr. Kalimullah.

**Step 2: Select a domain name.**

When it comes to selecting a URL for your website, short and simple is key according to Lindsay. “The shorter the better. Try to match the name to your practice. So many times, we’ll see that the practice is called ‘ABC Dermatology,” but the domain is ‘drsmith.com.’ Try to bring those things together, so that when someone tries to search there’s less confusion.

Domain names are regulated by ICANN, or the Internet Corporation for Assigned Names and Numbers. You can register a domain through an accredited list of domain registrars on the ICANN website, with the fee for your domain name depending on which registrar you choose. A list of reputable domain registrars is available on ICANN’s site at www.icann.org/registrar-reports/accredited-list.html. When selecting a domain name, dermatologists may want to consider buying all iterations of their name or practice name (for example, stephenjonesmd.com, stephenjonesmd.org, etc.) to avoid potential scammers or confusion among patients.

Don’t have a website yet? You can still purchase a domain name before you’ve selected a hosting service. This
is called “parking” a domain and is a way of reserving a particular address until your website has been created.

**Step 3: Find a host.**
After establishing a domain name, the next step is to find a website hosting service to make your site accessible online. Dermatologists should carefully vet potential web providers by taking into consideration price, customer reviews, and how long they’ve been in business. Physicians should also be careful to negotiate control of their site and its content in the event they switch host providers, and to retain access to their site’s passwords.

**Step 4: Make it mobile friendly.**
While oft repeated, the importance of a mobile-responsive site is increasingly critical as the number of patients searching for a doctor on a mobile device begins to overtake desktop usage. “Having a mobile-friendly site was very important to us, and we made sure to thoroughly review both the desktop and mobile versions of our site before going live,” said Dr. Kalimullah.

Moreover, the mobile friendliness of a site also affects its search rankings, according to Lindsay. “In May 2015, mobile searches surpassed desktop searches, which is something that Google has taken into account. As technology evolves and changes over time, that’ll even come into play with voice searches like Alexa and Siri,” he said. “Making sure the website is optimized for mobile is probably the biggest thing physicians can do, because that’s going to enable them to rank higher, and as technology changes and voice search becomes the norm, eventually someone’s going to say, ‘Find me a dermatologist with four stars.’”

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**Q:** Is online appointment-making a requirement for dermatology practices?

**A:** I think that’s becoming the expectation now. The dermatologist or office manager might not think it’s necessary, but a lot of people don’t necessarily want to call or talk to somebody on the phone. They want to book an appointment from the train, the bus, or at their house after office hours. Mobile really enables that ability, and as technology evolves and more people are moving to mobile, I think that’s becoming the standard.

— Jason Lindsay, Officite director of marketing
It’s time for a CLIA refresher!

BY FAIZA WASIF, MPH

Each month Dermatology World tackles issues “in practice” for dermatologists. This month Faiza Wasif, MPH, the Academy’s Practice Management Manager, offers tips on an area she commonly receives questions about from members.

What comes to mind when you hear CLIA? Probably that it’s just another burdensome federal regulation you must comply with. While it’s true that the Clinical Laboratory Improvement Amendments (CLIA) are federally mandated standards, they are more than just another regulation. It’s all about quality. Quality ensures that products or services are free from errors or defects. It’s how we can achieve uniformity and standards. It creates reliability and trust. It’s what every industry — particularly health care — strives to achieve.

So how does CLIA fit into health care quality, specifically? Let’s do a quick breakdown of its history and what it means to be CLIA certified.

CLIA was introduced in 1988 (with subsequent amendments) as federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research. Clinical laboratories must be licensed by the federal government and undergo continual accreditation to ensure compliance with all regulations placed under the responsibility of the Centers for Medicare and Medicaid Services (CMS).

Do you need to be CLIA certified?

CLIA requires all facilities that perform even one test, including waived tests, on “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings” to meet certain federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed. Even if you only read slides or use a microscope in your office, you must be CLIA certified.

What are the types of certifications?

There are five certification types — each valid for two years — depending on the type, number, and complexity of testing performed:

- **Certificate of Waiver**
  - This is given to facilities that perform only waived tests which are tests that are approved for home use, have simple methodology that assure accuracy, and pose little or no threat/harm to the patient if performed incorrectly. Some examples include pregnancy tests and urinalysis with dipstick.

- **Certificate of Provider Performed Microscopy Procedures (PPM)**
  - This is for moderately complex tests performed by a provider — primarily a microscope — when transfer of the specimen could affect accuracy. Examples of this include KOH slide preparation or evaluation for ectoparasites.

- **Certificate of Registration**
  - This is issued to a laboratory that enables the entity to conduct moderate- or high-complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations. Examples of moderate complexity testing include Tzanck tests and fungal cultures. High-complexity testing includes the reading of pathology slides. Only laboratories applying for a Certificate of Compliance or a Certificate of Accreditation will receive a Certificate of Registration.

- **Certificate of Compliance**
  - This is given after the inspection is complete and the lab is found to be in compliance with all CLIA regulations. It includes compliance with Mohs and other moderate- and high-complexity procedures. Most dermatology practices will apply for this certificate and renew it every two years.

To learn more about CLIA and get step-by-step guidance, check out the Academy’s CLIA for Dermatology manual at https://store.aad.org/products/8489.
Certificate of Accreditation
- This is issued to a lab on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. Usually, dermatology practices do not apply for this certificate. Find the list of accreditation organizations at www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/AOList.pdf.

How do you apply?
To receive a CLIA certification, a practice must apply using the CLIA application (Form CMS-116). This form collects information about your practice operation, which is necessary to determine the fees to be assessed, to establish baseline data, and to fulfill the legal requirements for CLIA.

You must also have a laboratory director in place for moderate- and high-complexity labs. The laboratory director qualifications are as follows:

Provider Performed Microscopy Procedure (PPMP): Lab director and testing personnel must have either an MD, DO, DPM, NP, or PA degree.

Moderate complexity: Lab director must have either an MD, DO, PhD, MS, or BS degree and have 20 hours of CLIA CME credit. The minimum requirement for testing personnel in this environment is a high school diploma.

High complexity: Lab director must be a certified pathologist or a physician with an MD or DO degree who received one year of laboratory training in residency or has two years of experience directing high-complexity testing. Testing personnel in this type of laboratory must have at least an associate degree in a field of science.

What happens after certification?
Once the appropriate certificate is obtained, it must be displayed in a prominent area and will need to be readily available upon request by CMS or a CLIA inspector.

Be prepared for an inspection at any time — although you are typically notified two weeks in advance of an inspection. The inspection's success hinges on the lab's condition and documentation at the time of the inspection. Here is what is typically covered:

Prior to inspection
- Provide basic lab information including business hours, test menu, and test volumes

During the visit
- Previous inspection report and related corrective action(s)
- Personnel files (both paper and electronic) for everyone involved with the lab
  - For the lab director, be sure to have documentation license (if physician), level of education, and experience/training
- Installation records for all instruments acquired since the last inspection for both new and replaced instruments
- Manuals and test procedures
  - These must be up to date, complete, and signed by the lab director
- Calibration verification, maintenance records, and service reports
- Quality control records
  - Including proficiency testing records (if applicable)
- Patient records
  - The inspector may request other information as well so be prepared by keeping all the documentation current and organized.

Am I required to do proficiency testing?
Proficiency testing is a way to verify your lab tests through an external source. CMS requires that all labs performing regulated analytes testing and are either a moderate- or high-complexity lab abide by proficiency testing guidelines. Most dermatology tests are not classified as regulated analytes. A full list of the tests requiring proficiency testing...

If you must enroll in a proficiency testing program, a list of approved agencies is available at www.cms.hhs.gov/CLIA/downloads/ptlist.pdf.

If you do not perform any of the tests on the list of regulated analytes, you do not have to enroll in a proficiency testing program, but you must assess the quality of your testing through two specimens twice a year. This can be done by splitting samples with another provider in your area and comparing results, or you can also enroll in a formal proficiency testing program. Remember, this requirement is in addition to the regular quality control you must also perform on all your tests.

Clearly, the CLIA regulations help ensure that standards are met, safety is not compromised, and redundancy is eliminated. When it comes to providing optimal care for your patients, knowing and abiding by these regulations will help your practice reach that goal each time. dw

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Answers in practice

Read archives of DW’s Answers in Practice column at www.aad.org/dw.
Medical malpractice stress syndrome

BY CLIFFORD WARREN LOBER, MD, JD

Every month, Dermatology World covers legal issues in Legally Speaking. Clifford Warren Lober, MD, JD, presents legal dilemmas in dermatology every other month. He is a dermatologist in practice in Florida and a partner in the law firm Lober, Brown, and Lober.

Question: What is medical malpractice stress syndrome?

Answer: Medical malpractice stress syndrome (MMSS) is a manifestation of post-traumatic stress disorder. Facing litigation is one of the most stressful situations a physician will ever encounter. Although one may intellectually understand that a malpractice suit is an inherent hazard of practicing medicine, it is psychologically devastating when it occurs. Instead of being respected, trusted, and valued, you are vilified and accused of professional incompetency or carelessness. Your judgment and character are questioned.

Regardless of whether the allegations have merit, physicians feel emotionally ambushed. A patient you have cared for and tried to help is now your accuser! You face months or years of litigation. Depending on the outcome, you may be reported to the National Practitioner Data Bank, the state Board of Medicine, and other regulatory authorities. Even if the case is dismissed or you are found not guilty, the fact you have been sued may have to be reported to hospitals, health care organizations, and others.

Q: What are the symptoms of MMSS?

A: MMSS has a variety of manifestations. Reactions of shock, anger, denial, and frustration are normal. Impairment of concentration, distractibility, difficulty sleeping at night, chronic fatigue, irritability, self-doubt, and a sense of helplessness occur as one’s personal integrity and competency are attacked. To make matters worse, you are instructed by your attorney to not discuss details of the case with anyone other than the attorney and your spouse. This leads to feelings of isolation and loneliness. Physicians accused of malpractice have even committed suicide.

Q: How often are physicians sued?

A: Although the obvious cause of MMSS is a malpractice lawsuit, even a formal complaint or investigation can trigger the symptoms of MMSS since they bring into question a physician’s competence, judgment, integrity, or character.

Q: How often are physicians sued?

A: Jena and colleagues analyzed data from 1991 through 2005, and reported in the New England Journal of Medicine that, “By the age of 65 years, 75% of physicians in low-risk specialties and 99% of those in high-risk specialties were projected to face a claim.” Dermatology was considered a low-risk specialty. These findings should not be surprising, however, given the number of patient encounters a physician faces. Assuming a physician sees 30 patients a day, five days a week, for 50 weeks a year (taking two weeks for vacation), they would have 7,500 patient encounters annually, or 75,000 encounters every 10 years! Each individual instance provides the opportunity for a patient to perceive an adverse experience.

Q: What do physicians do after being sued?

A: Physicians accused of malpractice may view patients as potential lawsuits walking on two legs. They may distance themselves from their patients, order more tests, request more second opinions, or refuse to treat patients with certain conditions. It is not uncommon for older physicians nearing the end of their careers to decide to quit practice when faced with a malpractice suit.

Q: How does MMSS affect a physician’s personal life?

Suggested topics

Do you have suggestions for topics to be discussed in this column? Email them to dweditor@aad.org.

Medical malpractice stress syndrome (MMSS) is a form of post-traumatic stress disorder that predictably results from lawsuits, as well as from allegations of incompetence and investigations.

Shock, anger, denial, and frustration are normal reactions. Impairment of concentration, distractibility, difficulty sleeping at night, chronic fatigue, irritability, self-doubt, and a sense of helplessness may occur as your personal competency, judgment, integrity, and character are attacked.

Physicians with MMSS may distance themselves from their patients, order more tests, request more second opinions, refuse to treat patients with certain conditions, or decide to retire.

Physicians with MMSS should consult with their attorney who can give them a realistic expectation of the outcome of their case, as well as enable them to participate in decisions that will have to be made.

If you are unable to concentrate at work or sleep at night, or feel that anger or frustration are too great, speaking with a mental health professional is advisable. This is certainly recommended if you are considering using alcohol or drugs, or even thinking of suicide.

Key points

1. Medical malpractice stress syndrome (MMSS) is a form of post-traumatic stress disorder that predictably results from lawsuits, as well as from allegations of incompetence and investigations.

2. Shock, anger, denial, and frustration are normal reactions. Impairment of concentration, distractibility, difficulty sleeping at night, chronic fatigue, irritability, self-doubt, and a sense of helplessness may occur as your personal competency, judgment, integrity, and character are attacked.

3. Physicians with MMSS may distance themselves from their patients, order more tests, request more second opinions, refuse to treat patients with certain conditions, or decide to retire.

4. Physicians with MMSS should consult with their attorney who can give them a realistic expectation of the outcome of their case, as well as enable them to participate in decisions that will have to be made.

5. If you are unable to concentrate at work or sleep at night, or feel that anger or frustration are too great, speaking with a mental health professional is advisable. This is certainly recommended if you are contemplating using alcohol or drugs, or even thinking of suicide.

6. Medical malpractice allegations are predictable hazards of our profession.

Links *in* the care chain

Dermatologists are key players in multispecialty care of melanoma, serious skin disease
A diagnosis of advanced melanoma marks the beginning of a difficult journey for patients. Dermatologists are increasingly involved with the care of these patients, in collaboration with oncologists and other specialists. Some of these dermatologists specialize in advanced melanoma and serve as critical members of a multispecialty care team. Others seek the expertise of surgical and medical oncologists when they discover melanoma in one of their patients.

*Dermatology World* spoke with three dermatologists who collaborate with other specialists to care for patients with advanced melanoma, and one who treats a variety of disorders in a pediatric cancer clinic. They explored the role of the dermatologist in a multidisciplinary care team, how the teams function, and how community dermatologists can connect their patients with oncology specialists. >>
Team dynamics and the dermatologist’s role

At the University of Wisconsin-Madison School of Medicine and Public Health, a diagnosis of Stage IB melanoma or higher typically triggers the involvement of specialties beyond dermatology, said Yaohui Gloria Xu, MD, associate professor of dermatology. “Those patients deserve to hear whether they’re a candidate for sentinel lymph node biopsy, which might be done by a surgical oncologist, or — if it’s on the head or neck — an ENT who specializes in head and neck cancer.” Patients who are elderly or have significant comorbidities may decline the biopsy and opt for local excision only; then “they might still come back to us for their care,” said Dr. Xu. A medical oncologist would normally be consulted for a patient at stage III or IV, but “there is a little gray zone. A patient could be lower than stage III, maybe IIB, but have a high risk of local/regional recurrence. Then we might still involve the medical oncologist to see if adjuvant therapy should be considered. While systemic adjuvant therapy is currently only approved by the FDA for patients with resected melanoma that is stage IIIA or greater, there are clinical trials currently in progress to study the potential benefit of adjuvant therapy for patients with resected stage IIB melanoma.”

The melanoma tumor board at UW tackles particularly complicated cases of advanced melanoma, where the optimal path for treatment isn’t clear, said Dr. Xu. After one unsuccessful attempt to establish a board when she first arrived, in 2014 she succeeded in her efforts to persuade other specialists that rapid advances in the treatment of advanced melanoma would yield enough cases to support twice-monthly meetings. “My medical oncologist is the main driver now, but in the beginning, he needed a little push,” she remarked. “I approached him and a few other key players in surgical oncology, radiation oncology, radiology, and pathology. As junior faculty, I didn’t have an established relationship with these colleagues, but after a few years navigating the system, they knew me as more than a colleague because we share patients together — more like a friend.”

Dr. Xu describes the dermatologist’s role on the board as supportive. “We follow the patients for general skin checks and treat cutaneous side effects. We’re in the car, but not the driver.” In one recent case, however, she alerted the group that small reddish nodules a half-inch away from a skin graft (performed after excision of pigmented melanoma) could be amelanotic melanoma. “I said we needed to biopsy those as well. It was an in-transit mass, a local-regional recurrence, so not an ordinary recurrence, but worse. The surgeon said based on these biopsies, this is way beyond the graft site, so not a good case for surgery. These are the cases that present routinely on the tumor board. Sometimes nobody knows what to do, there’s not enough data, but at least you have a reasonable consensus.”

The melanoma tumor board at the University of Texas MD Anderson Cancer Center typically reviews patients “whose disease is progressing, and we’re having a multidisciplinary evaluation as to whether they could be surgically cleared; if not, then what combination of radiation therapy and systemic therapy is appropriate for the next step in their care,” said Kelly C. Nelson, MD, associate professor of dermatology. “We’ve also discussed patients who have subtle tumors for which the surgeons may be having trouble clearing the margins. That’s really where the dermatologist becomes very engaged, to help define the extent of disease involvement.” Outside of the tumor board, Dr. Nelson’s role in team care varies by patient, she explained. “We care for patients who have advanced cancer of all different types. Over time, I’ve served in a role of almost a palliative dermatologist. Patients may have metastatic deposits from any cancer on their skin, and sometimes those can be a challenge from a bleeding standpoint. We also serve in this role of trying to optimize patients’ quality of life, even when they are at an advanced stage of disease.”

Like Dr. Nelson, Jennifer Huang, MD, helps manage the complications of cancer treatment, but her patients are children seen at the Jimmy Fund Clinic, the pediatric oncology department at Dana-Farber Cancer Institute. “I take care of rashes that patients get from chemotheraphy, and more and more I’m seeing rashes from targeted anti-cancer therapy,” she said. “Another subset of patients that I see are those with graft-versus-host-disease (GVHD) who have received bone marrow transplants. The skin is the most common organ involved in GVHD, and both acute and chronic GVHD can be quite severe. I also take care of cancer survivors, doing regular skin checks on patients exposed to radiation and immunosuppression.”

Dr. Huang runs a monthly dermatology clinic at the Jimmy Fund Clinic and often sees patients with a medical oncologist, an arrangement she characterized as “really rewarding. We’re learning from each other, and the patient gets one single message, which is nice.” She said she views the oncologists as the “primary care providers, responsible for taking care of the patient as a whole,” but emphasized that the specialists have a lot to teach each other. “Often I will be in a situation where the oncologist wants to stop treatment because the patient has some sort of skin reaction,” she remarked. “As dermatologists, we can identify what skin conditions are and are not life-threatening, and guide the oncologist in managing the patient’s oncologic therapy.”

Collaboration with oncologists was the topic of a popular session at the most recent AAD annual meeting. Jason C. Sluzevich, MD, dermatologist and dermatopathologist at the
Mayo Clinic in Jacksonville, Florida, said his talk focused on how dermatologists can facilitate collaboration in the management of patients with advanced melanoma and cutaneous T-cell lymphoma. “The landscape has changed because medical treatment for melanoma has become much better, so there’s an increasing role for adjuvant therapy,” he noted. In an integrated health practice like the Mayo Clinic, “it’s very easy to send people to other specialists. However, a lot of dermatologists either practice solo or they’ll just be in a group of dermatologists. Many are not associated with a hospital system, so we discussed how, as an independent dermatology practitioner, you can build a go-to team that you can refer patients to and know they will get the right type of care in the long term.” One approach is to attend CME events that are focused on melanoma treatments. “That’s a good way to learn something new and also meet many of the specialty providers who treat melanoma,” Dr. Sluzevich said. “Another strategy is to develop a relationship with an integrated practice group that either has a certification as a cancer center, or certain people who specialize in melanoma.”

When a primary care dermatologist refers a patient, “I try to reach out to those providers to thank them and let them know that I will keep them abreast of developments in the patient’s care, so they’re not left in the dark,” said Dr. Nelson. “Some of them are comfortable in watching for recurrence and treating complications, and some are not. If they are, and it saves the patient from having to always travel to MD Anderson, we want to take advantage of that knowledge.”

**Ongoing care**

Although they provide expert opinion and care as needed, the dermatologists said their primary responsibility in a multidisciplinary care team is to conduct regular skin checks and manage complications of treatment, a challenge that is becoming more complex as new therapeutic drugs gain FDA approval. Guidelines from the National Comprehensive Cancer Network dictate the frequency of follow-up exams according to the stage of the patient’s melanoma. However, some patients require more active surveillance, said Dr. Nelson. “Patients with stage IIC, patients who have very aggressive tumors that have developed ulceration, or patients with stage III and greater typically have some sort of body imaging on a regular basis,” she noted. “Those patients will usually see a dermatologist along with the medical oncologist in the same visit, because when melanoma spreads to the skin as a metastatic deposit, it can be much harder for the scans to show that. You need a skilled dermatologist to examine the skin, palpate the lymph nodes, and try to find those areas that may have come back on the skin as early as possible.”

**Our eyes are trained to see things that other physicians may find hard to see, like recurrent amelanotic melanoma, or syphilis of the skin. Also, I think [collaborative multidisciplinary care] makes patients feel cared for and reassured. They enjoy seeing the camaraderie and respect that we have for each other.”**

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**New drug combinations for melanoma**

The FDA has approved the following combinations of drugs to treat advanced melanoma:

- **dabrafenib (Tafinlar)** + **trametinib (Mekinist)**
- **encorafenib (Braftovi)** + **binimetinib (Mektovi)**
- **vemurafenib (Zelboraf)** + **cobimetinib (Cotellic)**
follows her pediatric patients “as long as they want to be followed. Because I see cancer survivors, I’ve had a few patients who are in their 30s. At some point they feel like it’s time to transition to adult care, but as long as they’re still coming to the Jimmy Fund Clinic, I see them.” For young patients beginning targeted anti-cancer therapy, Dr. Huang meets with them “before they start treatment” and does “some counseling about what to expect.” During treatment, she sees them every three months “because so many of them develop reactions.”

To a large extent, dermatologists rely on each other to stay abreast of the complications that can result from medical and radiation therapy, “I learn from my adult-patient dermatology colleagues, because drugs come into use a lot more slowly for kids,” said Dr. Huang. Dr. Nelson pointed to “some really great lectures at the AAD meetings that provide overviews of the current spectrum of cutaneous adverse events related to targeted immunotherapeutics. Plus, I’m grateful to have Dr. Anisha Patel, who’s an expert in this space, right down the hall from me. If I see something that I’m not sure about, I just ask her.” Dr. Sluzewich maintained that most cutaneous side effects of melanoma treatment “are pretty well documented, so if you’re up to date with the literature, you’ll find they’re well described.” What bears watching, he noted, is that “the threshold for using these medicines is probably going to get lower and lower, so I would keep a particular eye out for when will these adjuvant therapies start being applied to patients outside of known metastatic disease, but with other clinical features that are considered very high risk.” Dr. Nelson agreed that dermatologists need to be aware of changing indications. In addition, she noted, new combinations of existing targeted therapies are yielding, in some cases, side effects that are different from those resulting from either agent used alone. “Sometimes the reactions are worse, but in the case of [BRAF inhibitor] dabrafenib and [MEK inhibitor] trametinib, the skin reactions are actually improved by adding in the MEK inhibitor. It’s kind of its own little neighborhood when we start making these combinations.”

**Keys to successful collaboration**

All four dermatologists agreed that multispecialty care is a win-win for physicians and patients. “Where I see the advantage is that we’re able to work with the oncologist to manage skin reactions to systemic therapy in a way that lets patients stay on their therapy longer,” said Dr. Nelson. “Our eyes are trained to see things that other physicians may find hard to see, like recurrent amelanotic melanoma, or syphilis of the skin. Also, I think it makes patients feel cared for and reassured. They enjoy seeing the camaraderie and respect that we have for each other.” Dr. Sluzewich maintained that “you can’t really effectively treat advanced melanoma patients without having some sort of interdisciplinary process at work. Sooner is better than later, and you should try to involve more players as early on as possible. It’s good to give people a heads-up, especially if the case is very complicated.” For community dermatologists who may feel “a bit siloed,” building collaborative relationships can yield benefits beyond helping their melanoma patients, he noted. “It gets a very favorable reception, and you may think that you’re just collaborating on difficult melanoma cases, but then it opens up doors to all kinds of different areas that can touch dermatology.”

Not surprisingly, the dermatologists emphasized the importance of clear communication with their colleagues in a multidisciplinary care setting. Empathy is also critical, said Dr. Huang, adding that she learned “the hard way” how best to collaborate. “I was really excited to develop an initiative to work with these patients and with the oncologist, and I had a vision of how it could be done. I learned that it really helps to understand someone else’s needs and someone else’s perspective before developing a model. It’s incredible how much more you can do if you start the conversation with ‘what do you need’ as opposed to ‘here’s my idea.’ Also, recognize that the oncologists are, in essence, primary care providers, and that that’s where they’re coming from, so while you have an important role, they’re ultimately the ones who are in charge and responsible for their patient.”

Dr. Xu advised that anyone seeking to establish a tumor board should ensure that participants have expertise and interest in melanoma, and that members will work well together as a group. In Dr. Nelson’s view, working well together means that “if I detect a new metastasis with one of our mutual patients, I’m going to walk down the hallway and say to my colleague, ‘I’m looking at this gentleman who’s our patient, and I think I found a new metastatic deposit. How can I best help you? Can I order his imaging? Can I do a biopsy today? Does he qualify for a study now that he has a new deposit of measurable disease?’ And from a patient care standpoint, the closeness of those relationships is only beneficial.”

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If you’re like me, you probably found Dermatology World’s July feature article that compared medicine today to medicine several decades ago very amusing. Back in the day...we didn’t have to wrestle with electronic health records. We didn’t have to keep up with the latest cybersecurity concerns. We didn’t have to spend hours each day fulfilling administrative requirements. We didn’t have to worry about the role of augmented intelligence (AI) in medicine and what it will do to patient care.

Indeed, we’ve been hearing more and more about convolutional neural networks that can classify images of skin lesions as benign lesions or malignant skin cancers, allegedly as well as board-certified dermatologists. Given this increased presence of AI in medicine — and dermatology in particular —your Academy Board of Directors is addressing this issue head on and has adopted a position statement that addresses AI and its role in medicine.

All told, the Academy supports AI that can deliver high-quality patient care by enhancing the physician/patient relationship. In a nutshell, the Academy argues that artificial intelligence should provide an assistive role to in-person care and expertise. Combining machine learning technology with human intelligence can create a synergistic approach to quality care.

In the Academy’s position statement, we also provided a framework for future directions in the development of AI that includes education, privacy issues, and advocacy. Essentially, it will be up to us to ensure that AI is developed effectively and implemented ethically. To do so, we must remain engaged in its development and implementation.

AI is really the crunching of big data. In the case of lesion identification, it is looking at many images to determine benign vs. malignant patterns. However, even more important is the “big data” collected through EHRs, claims, and pharmacies. The “paymasters” are starting to use AI to sift through it to determine who provides cost-effective quality care. We need to have our own big data to counter their big data, which we are developing through DataDerm™. In the future, those who have the data will have the upper hand in controlling their destiny in the health care arena. I say it might as well be us.

As physicians, do we need to fear machine learning? I don’t think so. I know that AI can be an uncomfortable concept, particularly in the medical world. However, as dermatologists we have done yeoman’s work adapting to the consistent changes we’ve faced within medicine over the years. We can adapt with regard to AI by harnessing it and pointing it in the direction where we need to go. It’s up to us to make sure that the quality of health care only improves as medicine inevitably continues to evolve. dw
What is the Academy doing to promote access to teledermatology?

Dermatology World digs into an issue that is affecting the specialty and discusses the Academy’s key activities to address and advocate on the issue.

The American Academy of Dermatology Association (AADA) advocates for policies that protect patient safety while enabling dermatologists to appropriately use teledermatology services to meet the needs of communities and populations across the country. The Academy has also developed several educational resources for physicians on telemedicine implementation.

**Advocacy activities:**

The AADA recently responded to a request for information (RFI) from the Congressional Telehealth Caucus co-chairs and Senate telehealth leaders on best practices for telemedicine. These congressional telehealth leaders intend to introduce a telehealth package later this year based on the feedback stakeholders, such as the Academy, send them. In its response, the AADA:

- Reiterated its support for the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act in the 114th and 115th Congresses — specifically the provisions that would ensure patient choice of provider as well as those providing for appropriate supervision of nonphysician practitioners and respecting state licensure requirements.
- Highlighted information regarding the Academy’s telehealth program, AccessDerm, as well as Project ECHO (Extension for Community Healthcare Outcomes) — an online learning collaborative model of medical education and care management that the Academy supports.

**Resources for physicians and patients:**

The Academy’s Teledermatology Toolkit offers physicians resources on telemedicine implementation, as well as innovative ways to improve access for patients. The toolkit will be expanding to include four additional modules:

- Fundamentals of Teledermatology online courses (four additional modules COMING SOON!):
  - Module 1: Disaster Relief
  - Module 2: Pediatric Dermatology
  - Module 3: Teledermoscopy
  - Module 4: Dermatologic Surgery
- An interactive map with state-by-state information on telemedicine rules and regulations
- Compliance and implementation resources
- Reimbursement information
- Physician stories about telemedicine

Check out the Academy’s Teledermatology Toolkit at [www.aad.org/teledermatology](http://www.aad.org/teledermatology).

Join AccessDerm

Volunteer to join AAD’s philanthropic teledermatology program, AccessDerm, designed to deliver dermatologic expertise to underserved populations. Learn more at [www.aad.org/members/volunteer/accessderm-teledermatology-program](http://www.aad.org/members/volunteer/accessderm-teledermatology-program).

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*Dermatology World* digs into an issue that is affecting the specialty and discusses the Academy’s key activities to address and advocate on the issue.
What is the status of MAC implementation of the NCCI new procedure-to-procedure edits for the new biopsy codes?

As of July 1, 2019, service modifiers 59 and XE, XS, XP, and XU may be appended to either Column 1 or Column 2 codes in the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits table, when appropriate.

On March 29, the Centers for Medicare and Medicaid Services National Correct Coding Initiative (CMS/NCCI) announced changes to the column1/column2 sequencing for PTP edits, when appropriate.

The NCCI edit change indicated that Medicare Administrative Contractors (MACs) will allow modifier 59 to be appended on either the Column 1 or Column 2 code of a PTP edit with a modifier indicator of "1". Additionally, regardless of which of the two paired codes identified in the NCCI PTP Column 1/Column 2 edits receives a 59 modifier, the claim will be paid.

The Academy informed and confirmed from CMS that the MAC’s policy — to strictly require the modifier be appended to the Column 2 code of the PTP code pair — was erroneous. A claim with a modifier appended to the Column 1 code would not be paid.

To correct the error, CMS issued MLN Matters Number: MM11227 (Change Request: 11227) stating that effective July 1, the MACs will accept the modifiers on either Column 1 or Column 2 codes.

Learn more about this issue and test your knowledge in Dermatology World at www.aad.org/dw/monthly/2019/april/modifier-madness.
Are you ready to lead? Nominations sought for 2020 AAD election.

The American Academy of Dermatology Nominating Committee seeks nominees for the offices of President, Vice President, Board of Directors, and Nominating Committee Member Representative (West Region).

For the 2020 AAD Election the president-elect and vice president-elect candidates will participate in the following activities:

President-elect and vice president-elect:
- town hall during the Annual Meeting in Denver
- post-election videochat interview with successful candidates

President-elect:
- pre-election videochat interview
- five (5) minute speech on March 22 during the Annual Business Meeting

Submit nominations / Complete nominee materials / View reference materials
www.aad.org/aadnominations

CONTINUED ON PAGE 48
**PRESIDENT-ELECT CANDIDATES MUST AGREE TO ABIDE BY THE FOLLOWING EXCERPT FROM THE ADMINISTRATIVE REGULATION ON CODE FOR INTERACTIONS WITH COMPANIES**

1.4. No Key Society Leader, defined for purposes of this Code as the Presidential-level of a Society’s membership organization (e.g., the President, President-Elect, and Immediate Past President as applicable) may have Direct Financial Relationships with Companies during his or her term of service.

**Direct Financial Relationship**: A Direct Financial Relationship is a relationship held by an individual that results in wages, consulting fees, honoraria, or other compensation (in cash, in stock options, or in kind), whether paid to the individual or to another entity at the direction of the individual, for the individual’s services or expertise. As used in this Code, the term Direct Financial Relationship does not mean stock ownership or intellectual property licensing arrangements.

8 **Definition**: A Direct Financial Relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099 or equivalent income report. Key Society Leaders (including the President, President-Elect, Immediate Past President, the Secretary-Treasurer, Assistant Secretary-Treasurer, the chief executive officer of a Society’s membership organization, and the Editor(s)-in-Chief of Society Journal(s) may provide uncompensated service to for-profit health care products companies (“Companies”) and accept reasonable travel reimbursement in connection with those services. Key Society Leaders may accept research support as long as grant money is paid to the institution (e.g., academic medical center) or practice where the research is conducted, not to the individual. Exception may be made in certain circumstances for provision of consultant or investigator expertise related to protocol development and/or safety monitoring or any other consulting work related to one’s own past, current or potential research studies as long as the activities are not related to marketing or promotional efforts. In this event, the Secretary-Treasurer must be provided with background information and approval must be provided in advance for an exception to the policy. In these circumstances, compensation to the individual may not exceed $10,000/company/year. Verifying 1099 forms must be submitted to the Secretary-Treasurer when received. This exception may not be applied to the President, who shall remain free from any and all direct financial relationships during his/her term of office.

The Administrative Regulation on Nomination and Election Procedures requires that nominees submit all required materials to the Nominating Committee no later than Oct. 1.

For more information, contact the AAD Executive Office at californominations@aad.org or (847) 240-1046.

**NOMINATING COMMITTEE**

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**AUTHORIZED MEMBER ACTIVITIES**

No member of the American Academy of Dermatology shall directly contact any member of the Nominating Committee regarding nominees under consideration. Any lobbying of committee members may eliminate the nominee from consideration by the Nominating Committee.

No nominee, slated nor write-in candidate(s), may engage in any campaign activities prior to the official announcement of the slate of candidates on February 25, 2020. Both slated and write-in candidates should discourage others from campaigning on their behalf prior to the slate announcement. Violation of this rule may result in disqualification of the candidate.
Apply today for Academy leadership programs

In order to encourage dermatologists to take leadership roles in their specialty going forward, the Academy is seeking applicants for three leadership programs in 2020.

Leadership Forum
The 2020 Leadership Forum will bring together aspiring leaders in dermatology with experienced mentors to enhance their communication and leadership skills. The event will take place May 1-3, 2020, at the Eaglewood Resort near Chicago. Aspiring leaders will engage in an interactive program with colleagues and Academy leadership, and will learn critical competencies for physician leaders, including self-assessment and leveraging innate skills. It is open to dermatologists in both private-sector practice and academic settings. The Academy will provide travel and lodging expenses, as well as on-site meals for the Leadership Forum. Applications will be open July 1 through Oct. 1, 2019. For more information on the 2020 Leadership Forum, visit www.aad.org/LeadershipForum.

Academic Dermatology Leadership Program
The Academic Dermatology Leadership Program is facilitated by the Academy to provide physicians in academic settings the resources to meet the unique challenges of life in academia. A total of 18 Academy members will be chosen to participate in this highly selective program, which includes informative sessions at both the annual and summer AAD meetings, participation in the 2020 Leadership Forum, and opportunities to connect with an experienced mentor. This program requires a year-long commitment of between five and eight hours per month in addition to the on-site sessions. Applications will be open from July 1- Oct. 1, 2019. For more information on the Academic Dermatology Leadership Program, visit www.aad.org/ADLP.

Advanced Leadership Forum
The Academy also offers an Advanced Leadership Forum designed for mid-career level dermatologists. The event will take place May 1-3, 2020, at the Eaglewood Resort near Chicago, in conjunction with the Leadership Forum. Applications are open to all dermatologists, especially those with a particular interest in developing leadership skills that are transferrable to both practice and advocacy settings. Eligibility requirements include the member being 10 years out of residency training or six years past Leadership Forum attendance. Applications will be open from July 1 through Oct. 1, 2019. For more information on the Advanced Leadership Forum visit www.aad.org/AdvancedLF.

Applicants sought for research excellence award for young dermatology investigators
Each year the Academy recognizes outstanding basic, translational, and clinical research by young dermatology investigators through the AAD Young Investigator Awards. The purpose of the award is to acknowledge significant research advances in the science and practice of dermatology by those beginning their research careers who are likely to become established, independently funded investigators in dermatology.

For 2020, the Academy is offering a basic/translational research award track and a clinical research award track. One basic/translational researcher and one clinical researcher will be selected as the recipients of the 2020 awards. Each recipient will receive a $6,000 prize. The award selection panel will evaluate submissions for originality of the research concept, soundness of the research design, quality and clarity of the narrative research description, perceived value of the research to dermatology, quality and strength of publications, and an overall assessment of the applicant’s potential.

Applications for the 2020 awards are being accepted until Sept. 15, 2019. Eligibility criteria and online submission information are available at www.aad.org/young-investigator-awards. For more information, contact Allen McMillen at amcmillen@aad.org. - ALLEN MCMILLEN

These awards are made possible in part by a contribution from Helen Gruber in memory of her husband, Murray Gruber.
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American Academy of Dermatology

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Phone: (847) 240-1770
Despite rising burnout rates among all physicians, according to the AAD 2019 Life in Practice Study, the vast majority of dermatologists still enjoy what they do. Overall, 72% — or 7 in 10 dermatologists — say they are happy at their current job, regardless of practice setting or ownership. [See June’s Facts at Your Fingertips for more on dermatology management and practice ownership trends at www.aad.org/dw/monthly/2019/june/facts-at-your-fingertips.]

For a more complete breakdown of dermatologists’ current job satisfaction, see the chart below. dw

Dermatologist job satisfaction

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Overall happiness

Very Happy 39%  Happy 34%  Neutral 15%  Unhappy 7%  Very Unhappy 5%

Very Happy  Happy  Neutral  Unhappy  Very Unhappy
Do your patients know it’s Psoriasis Awareness Month?

Treating psoriasis has benefits for the body and mind

Treatment can reduce itch and pain, support a good night’s sleep, and improve self-confidence.

Ask your dermatologist which treatment options are right for you.

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