CAPITOL BATTLE

DERMATOLOGY’S AGENDA AWAITS ELECTION OUTCOME

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DEAR READERS,

All of America has become increasingly diverse.

Growing up near New York City, I never knew anything else. As the entry port for many, people often settled down no further than a few minutes from Ellis Island. No one, however, understood the changes that the last few decades would bring. Immigrant communities have migrated to every corner of the U.S. Rural towns not only have all of the same strip mall shops, but also have ethnic restaurants and markets. We truly are no longer a country of the descendants of the Mayflower.

The impact on dermatology of this diversity is the subject of our feature on cultural sensitivity. We not only look different, but also have different beliefs and skin practices. We need to be sensitive to these cultural differences. I especially liked Dr. Pandya’s comment that “cultural competence is central to professionalism, and it should include humility, empathy, curiosity, respect, sensitivity, and awareness.” And what about the impact of diseases on people of different backgrounds? It is misguided to assume that the response will be universally the same. We are reminded that it can be influenced by a community. John Harris, MD, PhD, talks about the impact of vitiligo on peoples of Indian descent in comparison to those of other cultures. Other times, as we all well know, the response to disease is highly individually. Temitayo Ogunleye, MD, reminds us that it is best to try to treat people “by using the hair care practices that they’re used to.” We as a country have always been strengthened by willingness to welcome others to our midst; we now just have to be sure that our dermatology practices reflect this.

Tele dermatology has the potential to be a big part of dermatology, but how will it be organized? The upcoming election may determine the answer. Sabra Sullivan, MD, PhD, tells us that “before tele dermatology can go live, state licensure issues, liability concerns, reimbursement mechanisms, and appropriate coding all must be addressed.” We learn in this month’s feature story that the Interstate Medical Licensure Compact proposed by the Federation of State Medical Boards (FSMB) could lift the current licensure restrictions so that qualified physicians would be eligible for expedited licensure in all participating states. This sharing of information and processes across state borders is essential to allow this technology to really take a leap forward. Options under consideration range from the FSMB compact to a national license solution. Perhaps neither of these may prevail. One thing is clear though; there are important issues at stake for dermatology in this midterm election.

Hope that you are enjoying the fall. Here in Philly we are enjoying apples galore. I’ve been munching while working on this issue. Hope you are too.

Enjoy your reading.

from the editor

ABBY S. VAN VOORHEES, MD, PHYSICIAN EDITOR
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Global surgery period

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.

Your office bills CPT 11100 to Medicare for a diagnostic biopsy of a clinically atypical nevus. The subsequent electronic remittance reveals that you are being paid absolutely nothing for your legitimate and medically necessary service. Why is that? The answer: improper billing during the Global Surgery Period.

The Global Surgery Period for each procedure in the CPT is either zero days, 10 days, or 90 days. This means that during a zero-, 10-, or 90-day expanse following a procedure all routine visits related to the procedure, such as bandage changes, wound checks, and suture removals are included in the procedure’s valuation, as they are part of the “global surgical package,” and are not to be billed to the insurer or to the patient. However, if unrelated necessary services are done during the global surgical period, then these separately identifiable services are billable with an appropriate modifier. The commonly needed (and occasionally overlooked) modifiers for use during the global period are:

- 24: Unrelated E/M service by the same physician or other qualified health care professional during a postoperative period
- 25: Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service
- 57: Decision for surgery (refers to E/M service resulting in a decision to perform a 90-day global surgery the day of or day after the evaluation)
- 79: Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period
- 58: Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period

The chart documentation must adequately justify the use of any modifier during the post-operative period. Particularly in the case of modifier 24, “Unrelated E/M service,” one must clearly document that the E/M service is totally unrelated to the preceding procedure. Absent or improper modifier use is a major reason for claims rejection and non-payment. The billing staff must remain vigilant to ensure proper modifier selection, use, and corrected use in the case of claim rejection.

In order to properly determine the need for a modifier one must first decide whether a service falls within the postoperative period. A zero-day global means that any necessary services subsequent to the day of surgery may be billable without a modifier. The global period for a 10-day post-operative period includes the day of the procedure plus 10 days starting the day after the procedure. The 90-day post-operative period includes the day before surgery, the day of surgery, and 90 days after the day of surgery. The global period for any CPT code may be found on the CMS searchable Medicare Physician Fee Schedule tool available at www.cms.gov/apps/physician-fee-schedule/overview.aspx. A detailed instructional guide on using the Web fee schedule and global period look-up module is provided in a Medicare Learning Network article at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How_to_MPFS_Booklet_ICN901344.pdf.

The chart on the next page summarizes the global periods for dermatology-relevant CPT codes.

There are certain services that, when performed by the same individual who does the surgery, are included in the procedure valuation and not billed separately. These are:

- Preoperative visits: day of surgery for 10-day global (minor) procedures and day before surgery for 90-day global (major) procedures
- Postoperative complications not requiring a return to the operating room
ZYCLARA®: Efficacy for the Full Field Treatment of Actinic Keratosis

TREATS THE FULL FACE OR BALDING SCALP WITH A METERED DOSE PUMP.

Indication
ZYCLARA (imiquimod) Cream 3.75% is indicated for the topical treatment of clinically typical, visible or palpable actinic keratoses (AK) of the full face or balding scalp in immunocompetent adults.1

Important Safety Information for ZYCLARA Cream
- Intense local skin reactions including skin weeping or erosion can occur after a few applications of ZYCLARA Cream and may require an interruption of dosing. ZYCLARA Cream has the potential to exacerbate inflammatory conditions of the skin, including chronic graft versus host disease.1
- Administration of ZYCLARA Cream is not recommended until the skin is healed from any previous drug or surgical treatment.1
- ZYCLARA Cream should be used with caution in patients with pre-existing autoimmune conditions because imiquimod activates immune cells.1
- Exposure to sunlight (including sunlamps) should be avoided or minimized during use of ZYCLARA Cream. Patients should be warned to use protective clothing (e.g., hat) when using ZYCLARA Cream. Patients with sunburn should be advised not to use ZYCLARA Cream until fully recovered. Patients who may have considerable sun exposure, e.g. due to their occupation, and those patients with inherent sensitivity to sunlight should exercise caution when using ZYCLARA Cream.1
- Avoid concomitant use of ZYCLARA Cream and any other imiquimod cream because of increased risk for adverse reactions.1
- In clinical studies for actinic keratosis, the most common adverse events involved skin reactions in the application area including erythema, scabbing/crusting, flaking/scaling/dryness, edema, erosion/ulceration, and exudate. Most local skin reactions were rated as mild to moderate.1

Please see Brief Summary of Full Prescribing Information on adjacent page.
References: 1. ZYCLARA Cream Package Insert. Scottsdale, AZ: Medicis, the Dermatology Company; February 2012.
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DM/ZCL/13/0004
**Zyclara Brief Summary**

**CONTRAINdications** None

**WARNINGS AND PREcautions**

Local Skin Reactions

Intense local skin reactions including skin peeling or erosion can occur after a few applications of ZYCLARA Cream and may require an interruption of dosing (see Dosage and Administration (2) and Adverse Reactions (6)). ZYCLARA Cream has the potential to exacerbate inflammatory conditions of the skin, including chronic graft versus host disease. Severe local inflammatory reactions of the female external genitalia can lead to severe vulvar swelling. Severe vulvar swelling can lead to urinary retention. Dosing should be interrupted or discontinued for severe vulvar swelling. Administration of ZYCLARA Cream is not recommended until the skin is healed from any previous drug or surgical treatment.

Systemic Reactions

Flu-like signs and symptoms may accompany, or even precede, local skin reactions and may include fatigue, nausea, fever, myalgias, arthralgias, malaise and chills. An interruption of dosing and an assessment of the patient should be considered (see Adverse Reactions (6)). Lymphadenopathy occurred in 2% of subjects with actinic keratoses treated with ZYCLARA Cream, 3.75% and in 3% of subjects treated with ZYCLARA Cream, 2.5% (see Adverse Reactions (6)). This reaction resolved in all subjects in 4 weeks after completion of treatment.

UV Light Exposure Risks

Exposure to sunlight (including sunlamp) should be avoided or minimized during use of ZYCLARA Cream. Patients should be warned to use protective clothing (e.g., a hat) when using ZYCLARA Cream. Patients with melanoma should be advised not to use ZYCLARA Cream until fully recovered. Patients who may have considerable sun exposure, e.g., due to their occupation, and those patients with inherent sensitivity to sunlight should be advised to use ZYCLARA Cream when they are not using UV-A or UV-B light sources.

In an animal photo-carcinogenicity study, imiquimod cream shortened the time to skin tumor formation (see Nonclinical Toxicology (13.1)). The enhancement of ultraviolet carcinogenicity is not necessarily dependent on phototransduction mechanisms. Therefore, patients should minimize or avoid natural or artificial sunlight exposure.

Increased Risk of Adverse Reactions with Concomitant Imiquimod Use

Concomitant use of ZYCLARA Cream and any other imiquimod products, in the same treatment area, should be avoided since they contain the same active ingredient (imiquimod) and may increase the risk for and severity of local skin reactions.

The safety of concomitant use of ZYCLARA Cream and any other imiquimod products has not been established and should be avoided since they contain the same active ingredient (imiquimod) and may increase the risk for and severity of systemic reactions.

Immun Cell Activation in Autoimmune Disease

ZYCLARA Cream should be used with caution in patients with pre-existing autoimmune conditions because imiquimod activates immune cells (see Clinical Pharmacology (12.2)).

ADVERSE REACTIONS

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Clinical Trials Experience: Actinic Keratosis

The data described below reflect exposure to ZYCLARA Cream or vehicle in clinical trials of ZYCLARA Cream in actinic keratosis that included a total of two or more double-blind, vehicle-controlled trials. Subjects applied up to two packets of ZYCLARA Cream or vehicle daily to the affected skin area (either entire face or balding scalp) for two 2-week treatment cycles separated by a 2-week to 4-week period.

Table 1: Selected Adverse Reactions Occurring in ≥ 2% of ZYCLARA-Treated Subjects and at a Greater Frequency than with Vehicle in the Combined Studies (AK)

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>ZYCLARA Cream, 3.75% (N=160)</th>
<th>ZYCLARA Cream, 2.5% (N=160)</th>
<th>Vehicle (N=160)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>10 (6%)</td>
<td>3 (2%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>Application site pruritus</td>
<td>7 (4%)</td>
<td>8 (4%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>7 (4%)</td>
<td>2 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Nausea</td>
<td>6 (4%)</td>
<td>1 (1%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Influenza like illness</td>
<td>1 (&lt;1%)</td>
<td>6 (4%)</td>
<td>0</td>
</tr>
<tr>
<td>Application site irritation</td>
<td>5 (3%)</td>
<td>4 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Pyrosis</td>
<td>5 (3%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anorexia</td>
<td>4 (2%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ooziness</td>
<td>4 (2%)</td>
<td>1 (&lt;1%)</td>
<td>0</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>4 (2%)</td>
<td>0</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td>Application site pain</td>
<td>5 (3%)</td>
<td>2 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Lymphadenopathy</td>
<td>3 (2%)</td>
<td>4 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Oral herpes</td>
<td>3 (2%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>2 (1%)</td>
<td>4 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Chelitis</td>
<td>3 (2%)</td>
<td>0</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

Local skin reactions were recorded as adverse reactions only if they extended beyond the treatment area, if they required any medical intervention, or they resulted in patient discontinuation from the study. The incidence and severity of selected local skin reactions are shown in Table 2.

Table 2: Local Skin Reactions in the Treatment Area in ZYCLARA-Treated Subjects as Assessed by the Investigator (AK)

<table>
<thead>
<tr>
<th>All Grades* (%)</th>
<th>Severe</th>
<th>ZYCLARA Cream, 3.75% (N=160)</th>
<th>ZYCLARA Cream, 2.5% (N=160)</th>
<th>Vehicle (N=160)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythema</td>
<td>96%</td>
<td>96%</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>Severe Erythema</td>
<td>25%</td>
<td>14%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Scabbing/Crusting</td>
<td>93%</td>
<td>84%</td>
<td>45%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Scabbing/Crusting</td>
<td>14%</td>
<td>9%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Edema</td>
<td>75%</td>
<td>63%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Edema</td>
<td>6%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Erosion/Ulceration</td>
<td>62%</td>
<td>52%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Erosion/Ulceration</td>
<td>11%</td>
<td>9%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Exudate</td>
<td>51%</td>
<td>39%</td>
<td>34%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Exudate</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Flaking/Scaling/Dryness</td>
<td>91%</td>
<td>88%</td>
<td>77%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Flaking/Dryness</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Scabbing/Dryness</td>
<td>91%</td>
<td>88%</td>
<td>77%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*All Grades: mild, moderate or severe

Overall, in the clinical trials, 11% (17/160) of subjects in the ZYCLARA Cream, 3.75% arm, 7% (11/160) of subjects in the ZYCLARA Cream, 2.5% arm, and 0% in the vehicle arm received required periods due to adverse local skin reactions.

Other adverse reactions observed in subjects treated with ZYCLARA Cream included: application site bleeding, application site swelling, chills, dermatitis, herpetic lesions, herpes simplex, herpes zoster, hyperpigmentation, iridocyclitis, keratoconjunctivitis, keratitis, lethargy, myalgia, pancytopenia, pruritus, squamous cell carcinoma, and vomiting.

Postmarketing Experience

The following adverse reactions have been identified during post-approval use of imiquimod. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to estimate their frequency or establish a cause-effect relationship.

Skin: Frequency: application site reaction. Adverse events which occurred more frequently in imiquimod-treated subjects compared with vehicle-treated subjects are listed in Table 2.

Sustained hypotension was the most frequently reported local skin reaction. Severe local skin reactions reported by imiquimod-treated subjects in the pediatric studies included erythema (28%), edema (6%), scabbing/crusting (8%), flaking/scaling (5%), erosion (2%) and weeping/exudate (2%).

Systemic misoprostol of imiquimod across the affected skin of 22 subjects showed a reduction of 2 to 12 years with extensive MV involving at least 10% of the total body surface area was observed after single and multiple doses at a dosing frequency of 3 applications per week for 4 weeks. The investigator determined the dose applied, either 1, 2 or 3 packets per dose, based on the size of the treatment area and the subject’s weight. The overall median peak serum drug concentrations at the end of week 4 was between 0.26 and 1.96 ng/mL, except in a 2-year old female who was administered 2 packets of study drug per dose, had a Cmax of 9.96 ng/ mL after multiple dosing. Children aged 2–4 years received doses of 12.5 mg, children aged 4–11 years administered 25 mg (two 12.5 mg tablets) imiquimod multiple-dose peak serum drug levels of approximately 0.2 or 0.5 ng/mL. Children aged 6–12 years received doses of 12.5 mg, 25 mg, or 37.5 mg (three packets) and had median multiple dose serum drug levels of approximately 0.15, or 0.3 mg/mL, respectively. Among the children with evaluable laboratory tests, the median WBC count decreased by 1.4*10^9/L and the median absolute neutrophil count decreased by 1.42*10^9/L.

Geriatric Use

Of the 320 subjects treated with ZYCLARA Cream in the AK clinical studies, 150 subjects (47%) were 65 years or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects.

Clinical studies of ZYCLARA Cream for EGW did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Of the 400 subjects treated with ZYCLARA Cream, 3.75% in the EGW clinical studies, 5 subjects (1%) were 65 years or older.

OVERDOSAGE

Toxicology studies involving ZYCLARA Cream could result in an increased incidence of severe local skin reactions and may increase the risk for systemic reactions.

Hypotension was reported in a clinical trial following multiple oral imiquimod doses of ≥200 mg (equivalent to ingestion of the imiquimod content of more than 21 packets or pump actuations of ZYCLARA Cream, 3.75% for more than 32 packets of imiquimod cream or 2 packets of ZYCLARA Cream, 2.5%). The hypotension resolved following oral or intravenous fluid administration.

PATIENT COUNSELING INFORMATION


Revised: 02/2012
• Postoperative follow-up visits
• Dressing changes, surgical site care, removal of sutures or staples
• Control of postoperative hemorrhage, unless it involves a return to the operating room

If the decision to perform a minor (10-day global) procedure is made on the day of the procedure, it is customarily considered to be a preoperative service included in the minor procedure valuation.


Now, let’s return to the vignette featured at the start of this article. Why was the biopsy, CPT 11100, not paid? The explanation: the remittance advice stated that payment for the procedure was included in the payment for a previous procedure. It turns out that the previous procedure was a destruction of several actinic keratoses done eight days earlier. Since the destruction codes have a 10-day global period, the biopsy should have been billed with a 79 modifier to specify that it was unrelated to the procedure. The destruction of the actinic keratoses.

Example 1: An established patient with a family history of melanoma is evaluated for a changed mole on his back. You obtain a history for the lesion, examine it and, suspecting an atypical nevus, decide to excise it on the day of the visit. You bill for the excision and CPT 99212 for the evaluation.

You excise an atypical nevus on the chest of a patient on May 9. As the nevus turns out to be a melanoma, you promptly recall the patient and do a therapeutic wide excision on May 19. You bill for the melanoma excision with a 58 modifier appended to the excision and repair codes.

Example 2: A patient is referred to you for Mohs surgery. You evaluate the patient, decide that Mohs surgery is appropriate, and, as you are doing Mohs surgery that day, proceed to excise the nasal tumor and repair the defect with an advancement flap. You bill 17311 for one stage of Mohs surgery and 14060 for the flap repair. In addition, you charge for the initial patient evaluation leading to the decision for surgery, CPT 99202-57.

Answer: Incorrect. As the excision constitutes a minor, 10-day global procedure, the decision to excise the lesion is included in the procedure’s valuation. A separate E/M billing is not warranted, as only the lesion was evaluated and treated. However, if on the basis of the clinically atypical nevus a complete skin examination was done along with palpation of lymph node basins, and appropriately documented, that would have constituted a significant separately identifiable E/M service billable with a 25 modifier. Specifically for zero- and 10-day global procedures, the decision to do the procedure is included in the valuation of the procedure, and should not be billed with an E/M charge. However, if a separately identifiable E/M service beyond that resulting in the decision to do the procedure is done, then an E/M charge is acceptable. Both the procedure and the E/M charge can be referenced to one and the same diagnosis as long as a documented distinct E/M service is done (NCCI Manual, 2014).

Answer: Correct. As the visit culminated with a major surgical procedure (the flap repair) with a 90-day follow-up period the initial, same-day evaluation to determine the need for surgery with a 90-day period is billable with a 57 modifier and payable. In the above example, if a complex repair (10-day global) instead of a flap were done, an E/M charge of 99202 would not be appropriate, as the decision to do a zero- or 10-day global procedure is included in the payment for the procedure.

Example 3: You excise an atypical nevus on the chest of a patient on May 9. As the nevus turns out to be a melanoma, you promptly recall the patient and do a therapeutic wide excision on May 19. You bill for the melanoma excision with a 58 modifier appended to the excision and repair codes.

Answer: Correct. Since the second procedure was related to the first, and was done on the 10th day of the initial procedure’s 10-day postoperative period, the 58 modifier is necessary, as it distinguishes the service as related to but separate from the first excision.
Insurance companies have implemented many strategies to control the growing cost of medications and treatments. One of these strategies is known as step therapy, a process by which insurers require patients to first try and fail on certain medications that are believed to be less costly before a patient is granted coverage for the medication that had been initially prescribed by the patient’s health care provider. In 2010, nearly 60 percent of insurers employed the step therapy strategy. This strategy is affecting dermatology patients, and state legislatures are becoming more interested and active on the issue. While the AADA understands the need to contain health care costs, it is monitoring numerous bills across the country to ensure that ultimately, treatment and medication decisions are made by the physician, not the insurance company.

**Maryland** SB 622, signed by Gov. O’Malley in May, establishes a standardized process for a health care provider to request an override of the insurer’s step therapy protocol. The legislation also limits the duration of a step therapy protocol imposed by a specified insurer, nonprofit health service plan, or health maintenance organization. The legislation took effect July 1, 2014.

Similarly, **Massachusetts** SB 439 would create guidelines for the use of step therapy in drug formularies, and would allow physicians the opportunity to override an insurer’s step therapy protocol if the physician can provide certain clinical data. Additionally, the legislation would limit the amount of time a patient could be subjected to step therapy, prohibit insurers from requiring a patient to fail on the same medication more than once, and would adjust copays for those who have established — through step therapy — that a drug is medically necessary. This legislation was heard in committee but no vote has been taken.

**Connecticut** SB 394 — signed into law in late July 2014 — also allows for speedy override requests, prohibits insurers from requiring patients to fail a prescription drug more than once, and limits the trial of a step therapy to 30 days. The Connecticut General Assembly extended these step therapy protections to Medicaid enrollees in 2013, and this legislation — which will go into effect Jan. 1, 2015 — will apply to patients with commercial insurance coverage.

**Oregon** (SB 1539), **Rhode Island** (S 2501), and two **New York** bills (AB 5214 and SB 2711 — previously mentioned in the April 2014 issue of *Dermatology World*) would provide a clear and convenient process by which a prescriber can override the step therapy protocols. Oregon’s bill died upon the legislature’s adjournment, Rhode Island’s bill is being held in committee for further study until the start of the next session, and the New York bills remain in committee. - **VICTORIA PASKO**
Two widely read salary surveys show slight increase in dermatology compensation in 2013

SURVEYS OF DERMATOLOGY COMPENSATION offer dermatologists data they can use to benchmark their practices — and often create the foundation for outside impressions of the specialty. According to two of the best-known and widely reported compensation surveys, dermatology compensation increased slightly in 2013.

The median compensation for dermatologists was unchanged in 2013 according to the Medical Group Management Association’s (MGMA’s) 2014 Physician Compensation and Production Survey, based on 2013 data. The survey’s top-line data showed median compensation for dermatologists rose from $471,555 in 2012 to $475,163 in 2013. Specialists in general saw a 2 percent increase in median compensation in 2013, according to MGMA. The figures for dermatology reported in the MGMA survey are based on responses from 344 dermatologists from 120 practices, along with 50 Mohs surgeons in 35 practices and 12 dermatopathologists from eight practices. Data without Mohs or dermatopathology, reported as the median for dermatology in some outlets, showed a compensation figure of $430,080.

The American Medical Group Association’s (AMGA’s) 2014 Medical Group Compensation and Financial Survey, based on 2013 data, showed a 1.9 percent increase in median compensation for dermatologists, from $411,499 in 2012 to $419,146 in 2013. The AMGA figures for dermatology are based on responses from 569 dermatologists, all of whom reported working in one of 115 groups, with 522 physicians working for groups with more than 150 physicians. AMGA also reported data from 67 Mohs surgeons with a median compensation of $602,634.

RICHARD NELSON

<table>
<thead>
<tr>
<th>Year</th>
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<th>AMGA</th>
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<td>2013</td>
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DO training programs to fall under ACGME system by 2020

WITH THE CURRENT HEALTH CARE REFORM INITIATIVES, there are increasing calls for American Osteopathic Association (AOA) and Accreditation Council for Graduate Medical Education (ACGME) residency-trained dermatologists to work together on a variety of initiatives. Formally acknowledging the need for unification and collaboration, the AOA, ACGME and American Association of Colleges of Osteopathic Medicine (AACOM) have agreed to form a single accreditation system for GME programs in the United States.

The agreement calls for AOA-accredited training programs to transition to ACGME recognition and accreditation. Both DOs and MDs will have access to all training programs; AOA and AACOM will become ACGME member organizations, and each will have representation on the ACGME Board of Directors. The new system will be fully implemented by July of 2020.

“This merger is a clear indication of the similarity of AOA and ACGME residency training programs today,” said Oliver Wisco, DO, chair of the AAD’s Ad Hoc Task Force on Doctors of Osteopathic Medicine. “The merger also provides the framework for the osteopathic and allopathic communities to come together to ensure the quality and efficiency of graduate medical education, as well as create a unified voice for dermatology,” Dr. Wisco added.

For more information on the single GME Accreditation System, go to www.acgme.org. – CINDY KUHN

Clarification

IN THE JULY 2014 ISSUE of Dermatology World, the article “A wide view on AKs” (www.aad.org/monthly/2014/july/a-wide-view-on-aks) included a sentence that quoted one physician’s experience regarding the cost of ingenol mebutate (brand name Picato®) for a patient’s monthly dose, which the manufacturer of the drug disputes. Dermatology World has been advised that the wholesale acquisition cost together with the manufacturer’s negotiation of further discounts with insurers, results in a significantly lower price for this drug than what was quoted in the article.

According to Leo Pharma: “When pricing a product, LEO Pharma aims at striking the optimal balance between access/affordability and revenue generation to support development of new and innovative patient solutions. In the case of Picato®, we have opted at a price level within the range of other branded products and even within the range of generic AK-topicals. Based on this “WAC price” (Wholesale Acquisition Cost), LEO Pharma has engaged in continuous negotiations with the insurance plans, to establish the best possible access situation for our product. These negotiations do result in specific and significant discounts (from LEO to the insurance plans) on the WAC-price in order to get the desired access position. As a consequence, the WAC-price does not reflect the cost of treatment, nor does it reflect the revenue generation to LEO Pharma and it indeed does not reflect the costs to patients...As a result of negotiations with insurance plans, LEO Pharma is pleased to share the fact that Picato® is today covered for the vast majority of your patients, more specifically for approximately 82 percent of patients on commercial plans and for approximately 68 percent on Medicare Part D plans. In addition to the achieved insurance coverage, LEO Pharma offers co-pay cards, which means that patients covered by a commercial plan for Picato® will have a co-pay in the range of $25 - $60 (the average being $40) and patients covered by Medicare Part D plans will have a co-pay in the range of $30 - $95 (average $65).”

Dermatology World appreciates the clarification and hopes it adds to readers’ knowledge as they seek the most effective way to treat their patients with actinic keratosis. dw
Can a new classification system help clinicians ID pigmented lesions?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Michael Piepkorn, MD, PhD, about his recent Journal of the American Academy of Dermatology article, “The MPATH-Dx reporting schema for melanocytic proliferations and melanoma.”

Q&A

DR. VAN VOORHEES: Why create a new reporting classification system for pigmented lesions? Is there discordance in the interpretation of all types of pigmented lesions?

DR. PIEPKORN: No, concordance is generally quite good for stereotypical melanocytic lesions with “textbook” features. An ordinary nevus would engender little if any disagreement. The same holds true for thick primary melanomas. Discordance exists because, simply put, there is an intractable histological “grey zone” between benign and malignant that on occasion cannot be resolved by the present criteria-based process for diagnosis.

DR. VAN VOORHEES: How do you define this grey zone?

DR. PIEPKORN: One could define grey zone lesions as those proliferations that share histological features crossing two or more conventional diagnostic categories. Criteria for the diagnostic categories have evolved over a century or more of histological alterations observed by our predecessors in histological sections of melanocytic lesions. Criteria historically tended to derive from stereotypical lesions, which were then extrapolated across the broad spectrum of proliferations encountered in daily practice. Few of the criteria have been rigorously vetted by correlation with the true gold standard, which is disease biology. Criteria are thus often “soft,” namely, there are limitations in their diagnostic sensitivity, specificity, and predictive value. Moreover, application of the criteria to given lesions is often subjective and thus not uniformly reproducible between observers.

DR. VAN VOORHEES: What impact has this lack of standardization of nomenclature had?

DR. PIEPKORN: Due to the existence of a histological grey zone in which lesions may have features, to a greater or lesser degree,
that overlap more than one conventional diagnostic category, leaders in the field of dermatopathology have tended to develop their own unique lexicon of diagnostic nomenclatures. The range of terminologies reflect personalized viewpoints regarding various aspects of melanocytic neoplasia, among which are histogenetic relationships between lesions and assumptions regarding stages in the putative pathways of neoplastic progression. Much of the range of personalized viewpoints stems from hypothetical arguments and is largely not empirically based. While it is understandable how this evolution in nomenclature evolved, the difficulties occur when recipients of pathology reports become confused by arcane terminology that can predispose to miscommunication, interventions (or lack thereof) that are not indicated, and harm to patients. A standardized reporting scheme, such as we have proposed in the MPATH-Dx algorithms, could potentially lessen miscommunication and errors of omission or commission.

DR. VAN VOORHEES: Is the lack of standardization unique to pigmented lesions? Are there things that you learned from other clinical fields that you applied to melanocytic pathology?

DR. PIEPKORN: The lack of standardization is clearly not unique to pigmented lesions but may be somewhat more of an issue in this field due to the complexity and range of the histological alterations compared with some other tumor systems. Our inspiration for MPATH-Dx, in fact, came about in part by our recognition that difficulties with standardization in the field of mammography led to government-mandated reform that eventuated in the BI-RADS paradigm implemented by the American College of Radiology for reporting of mammogram results. Implementation of that system has resulted in improvements in patient care and reduction in adverse medicolegal events.

DR. VAN VOORHEES: How did you develop the MPATH-Dx histology reporting form? What are its features? How did you categorize the various types of pigmented lesions?

DR. PIEPKORN: The MPATH-Dx histology reporting form developed by necessity when the experienced pigmented lesion pathologists “compared notes” during consensus reviews that followed independent interpretations of over 200 lesions. Basically, we faced substantial differences in interpretation and a confusing breadth of individual terminologies that we recognized as potentially confounding to clinicians and their patients in some situations. Taking inspiration from BI-RADS, we developed by iterative review a schematic document that attempts to group lesions and their diagnostic nomenclatures by certain global characteristics, namely presumed histogenetic relationships and degree of abnormality under the hypothesis that melanocytic neoplasia is developmental in nature and in part stepwise. In most instances, the three-member panel of experienced melanocytic lesion pathologists could agree on the grouping based on the hypothetical assumptions.

DR. VAN VOORHEES: There is also a diagnostic-treatment mapping tool as well, correct? How does this work?

DR. PIEPKORN: The diagnostic-treatment mapping tool seeks to standardize the language pathologists use to assign levels of perceived risk from given melanocytic lesions and their recommendations as to treatment that would be indicated, if any. It is assumed, of course, that standardized language regarding risk and treatment will reduce (although not eliminate) confusion in communication with the clinician and thereby lessen the potential for unintended errors of omission or commission in treatment of the patient. Under these presumptions, the diagnostic-treatment mapping scheme has broad analogies with the reporting form, but it carries the latter one step further by beginning the process of developing standardized language for the risk-treatment algorithms. For each category in the mapping tool there are, accordingly, columns that list the risk-treatment language we propose as a first step in initiating this process of standardization in the field of melanocytic lesion dermatopathology.

DR. VAN VOORHEES: Have other dermatopathologists given you feedback on this schema? Have they found it intuitive to work with? Is there any disagreement about some of the categories that you’ve created?

DR. PIEPKORN: We published our proposals in the January issue of the Journal of the American Academy of Dermatology and it is therefore early in the process. An editorial accompanying our paper by Dirk Elston, MD, did take issue with specific lesions grouped together under some of the headings, which is not surprising considering the diversity of opinions that exist in the field. It is our intent that the schema not be implemented until it has been vetted by professional societies in the field. The process of implementation of schema of these types, if they are to be implemented at all, should include a thorough review of groupings of specific lesions and word crafting of the specific language to be used to attempt standardization of risk assessment and the specific therapy that would be appropriate, if any, for the lesional groupings. 

For additional information regarding ASMS educational activities, membership opportunities, and patient resources, please contact:

Novella Rodgers, Executive Director    Tel: 800-616-2767 or 714-379-6262
American Society for Mohs Surgery    Fax: 714-379-6272
5901 Warner Avenue, Box 391          www.mohssurgery.org
Huntington Beach, CA 92649-4659   execdir@mohssurgery.org

Closure Course and Dermatologic Surgery: Focus on Skin Cancer

Hyatt Regency Grand Cypress, Orlando Florida

May 20-21, 2015 - Closure Course
This intense learning experience will provide didactic instruction and practical demonstrations of multiple closure techniques, anatomic site-specific discussions, and valuable pearls, designed to take dermatologists to the next level of derm surgery practice. An elective lab session featuring realistic visco elastic models will allow registrants to practice new and more complex closures, proctored by highly experienced Mohs surgeons. The material presented in the Closure Course is unique and will nicely complement the topics and activities offered in Dermatologic Surgery: Focus on Skin Cancer (see below).

May 21-24, 2015 - Dermatologic Surgery: Focus on Skin Cancer
Top experts in Cutaneous Oncology, Dermatologic Surgery and Dermatopathology will provide updates on a wide range of surgical and Mohs topics. Interactive forum and panel participants will discuss appropriate repair strategies for different types of surgical wounds as well as innovative approaches to melanoma treatment and a variety of medicolegal controversies in dermatologic surgery. Both Mohs and non-Mohs histopathology cases provided by leading dermatopathologists will be featured in the microscope laboratory. Mohs technicians and nursing personnel are welcome to attend these sessions to further their understanding of skin cancer treatment and enhance their contributions to quality patient care and surgical efficiency.

A separate, concurrent course for Mohs technicians will offer advanced topics geared to enhance the expertise of the practicing Mohs technician.

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Huntington Beach, CA 92649-4659   execdir@mohssurgery.org
t’s a sunny afternoon and Bryan returns from court. His receptionist tells him Albert, a dermatologist, is on the telephone and seems quite upset. Bryan begins the conversation.

Bryan: Good afternoon, Albert! It’s good to hear from you.

Albert: Bryan, you wouldn’t believe it. One of my patients who took an oral medication had a severe blistering reaction that resulted in him being admitted to the hospital. He sued the pharmaceutical manufacturer, but was told that it was my fault since I was a “learned intermediary.” What is a learned intermediary?

Bryan: The concept of a learned intermediary is legal doctrine that has been used since 1966 by pharmaceutical and device manufacturers to have their liability transferred to the prescribing physician. Simply stated, the manufacturer’s duty to warn is shifted from warning the patient to warning the prescribing physician. Unless it can be shown that he or she was inadequately informed or misled, it is the prescribing physician who has the duty to inform the patient of risks, contraindications, and side effects of prescribed medications.

Albert: Why should the responsibility be the physician’s? After all, the manufacturer produces the medication.

Bryan: Although the manufacturer has a duty to inform patients of the risks associated with its products, it virtually never interacts directly with the patient as the prescribing physician does. This direct, in-person interaction allows the physician to convey information more effectively than the manufacturer could. Furthermore, only the physician knows the unique medical history of each patient.
and is unequivocally in the best position to determine which medication is optimal for each patient given his or her particular medical circumstances.

Thus, in his or her “intermediary” position between the patient and the pharmaceutical company, the doctor is uniquely qualified to prescribe medications and inform the patient of their benefits and risks. Please remember, also, that the physician has a separate fiduciary duty, unrelated to the pharmaceutical manufacturer, to inform the patients of recognized risks and side effects that may reasonably occur.

Albert: How can I avoid the responsibility being shifted to me?

Bryan: It would have to be shown that you were either inadequately informed or misled by the pharmaceutical company. Is this reaction mentioned in the package insert? Did you receive any promotional materials from the company’s representative when they visited your office? If so, was the possibility of developing a blistering eruption mentioned? Is this complication generally recognized by dermatologists who prescribe this class of medications?

Albert: Yes, I received some flashy promotional material, but I do not remember reading anything about a blistering eruption developing. This reaction is not mentioned in the package insert and is certainly not generally recognized by my colleagues who prescribe this type of medication.

Bryan: That would suggest that either this reaction is an extremely rare, exceptional event or that you were inadequately informed. Should any potential allegation be raised against you, a court might also question whether you would have prescribed the medication if you had adequate and correct information at the time. In other words, if you had known that this medication might cause a severe blistering reaction, would you have prescribed it for the patient anyway? Perhaps it was the only medication available for this patient’s condition. If this was the case, the manufacturer’s failure to adequately warn would not have caused the patient’s injury since, it could be argued, he or she would have received the medication anyway.

Albert: Not at all! If I had known of this potential reaction I would have given the patient a different type of medication.

Bryan: If it was a reaction that was not reported in the package insert, contained in promotional materials given to you, and is not generally recognized by the profession, it is unlikely that a claim against you would prove successful.

Albert: Are there situations in which the learned intermediary doctrine does not apply?

Bryan: Some state courts have held that this doctrine does not apply in specific situations, such as in direct-to-consumer advertising where the patient’s involvement in decision making has been viewed as mitigating his or her reliance on the learned intermediary, or in mass vaccination programs where there is minimal or no direct physician involvement. That does not seem to be the case, however, in the present situation.

Albert: How can I avoid this situation in the future?

Bryan: You should be familiar with the approved indications for medications you prescribe. If you use a drug for an “off-label” reason, be familiar with the risks associated with that medication and obtain the patient’s informed consent. As in all cases, the documentation in your medical record will be critical. Please let me know if you hear anything further about this situation.

Albert: I certainly will. Thanks, Bryan!

If you have any suggestions for topics to be discussed in this column, please e-mail them to me at loberc@gmail.com. See the February 2013 issue of Dermatology World for disclaimers. dw
Informed consent: How technology can improve the process

In dermatology, informed consent is a component of a surgical procedure; current case law has established that failure to obtain informed consent makes a physician liable for negligence or battery, and may constitute medical malpractice.

Before EHR, consent was sometimes a verbal process and it was possible to misplace consent forms. Now that most doctors are using EHR, paper consent forms are often being scanned into the EHR. But the process of printing a consent form, filling in the name of the procedure, having the patient manually sign it, scanning the signed form, and then either filing or shredding the signed document, is very time consuming. It is possible, though, to save time and effort by documenting informed consent electronically.

PURPOSE OF INFORMED CONSENT

Informed consent has two purposes.

1. **Educate the patient regarding the proposed medical treatment.** Patients often forget what is spoken to them, so the most effective way to provide this education is to also provide something in writing in simple, easy-to-understand language, using non-medical terminology.

2. **Protect the doctor from liability.** Almost 6 percent of malpractice claims arise from problems with informed consent, according to the Physician Insurers Association of America (PIAA).

Regardless of how the education is provided, there can be no protection from liability without having proper documentation of the consent taking place before treatment. The goal of this article is to describe the available technology to support the full informed consent process in an automated, efficient manner. Informed consent is a process, not just a signature.

INFORMED CONSENT PROCESS

The informed consent process includes:

- Delivery of the education along with confirmation that the education was understood
- Presentation of the informed consent (or possibly refusal) form
- Patient acknowledgment via signature
- Documentation of consent in medical record

Technology is available to support each of
these steps in the informed consent process with products supporting all or part of the processes. The most widely available technology addresses the process of obtaining, tracking, and verifying patient signatures so this review will focus on this step of the process first. Then a review of technologies available for the other steps will be presented.

PATIENT ACKNOWLEDGEMENT VIA ELECTRONIC SIGNATURE

An electronic signature can be an image of a handwritten signature, a voiceprint, a signing with the click of a mouse or even signing by using a finger or mouse to trace a signature onto a document. These types of signatures present a number of legal verification problems including:

• There is no proof as to when the document was signed (before or after procedure)
• The image of the signature could have been copied from one document to another
• The document can be manipulated after signing

A more secure type of electronic signature is a digital signature. This type of signature links the document to the signer’s identity so that the signer’s information is permanently embedded into the document along with the date and time of the signature. A facsimile of the signature and evidence of the signature’s validity may be viewed by opening the PDF document. Any alteration of the document after being digitally signed will cause the digital signature to become invalid. A digital signature is legally enforceable.

If one of the purposes of informed consent is to provide legal protection for the doctor, then I believe doctors should focus on solutions that provide the highest level of signature verification to withstand rigorous legal scrutiny.

SIGNATURE TECHNOLOGY SOLUTIONS

There are several vendors that offer HIPAA-compliant solutions for obtaining a digital signature. Cloud-based solutions enable the consent document to be sent via email and signed online via a Web browser. Others only enable the signing onsite via an electronic signature pad. Some also allow for having several data entry fields with buttons, check boxes, fill-in responses, and more than one signature. A few even allow for data collected on the consent form to be integrated into specific fields of an EHR medical record.

CLOUD-BASED SERVICES

DocuSign, EchoSign, RightSignature, and SIGNiX are non-health care specific systems which make the e-signing process secure and simple. In a medical practice environment, the office sends a patient an encrypted email with a link to the informed consent form. The patient views the forms online, fills in the required fields, initial and signs where requested, and then submits the completed form. A copy of the form is then emailed to the patient and the doctor, and the practice can import the document into the EHR. These systems also maintain a cloud-hosted dashboard of all documents ever signed for the practice.

These systems vary in terms of features and prices. Pricing varies based on the number of users and number of documents. Expect to budget about $20 per user per month for unlimited documents. For a small, one-location dermatology practice, generally only one user will be needed.

If the patient is in the office, sending an email to obtain a signature online may not be the best process for obtaining consent. The SIGNiX solution offers a new capability of in-person signing. The office staff specifies that the document will be signed “in person” and the form may then be viewed and signed on an iPad or Windows 8 touch screen.

IN-OFFICE SIGNATURE PAD SOLUTIONS

Solutions which allow you to collect the patient’s signature on a digital signature pad or touch screen are ideal for obtaining patient informed consent.

Beyond obtaining a signature, technology is also available to support the education process.

Consent involves education, not just signing a form.

KEY POINTS:

1. “Consent issues” was the second-most-common legal matter reported in claims made against dermatologists over the last 25 years.
2. Solutions that allow you to collect the patient’s signature on a digital signature pad or touch screen are ideal for obtaining patient informed consent.
3. Beyond obtaining a signature, technology is also available to support the education process.
4. Consent involves education, not just signing a form.
and update demographics and insurance information during check-in, sign HIPAA forms, and pay co-pays using a built-in credit card swipe. The system can also present any type of educational content or form to a patient, including an informed consent form, to view and digitally sign. Phreesia is integrated with a number of EHR systems and can have the signed forms attached to the patient record.

EDUCATIONAL TECHNOLOGY
There are many systems that provide medical education to patients. In fact, providing educational materials to patients regarding their specific medical conditions is required by Meaningful Use. What is unique about a product called iMedConsent PE is that it generates this educational content in the format of an informed consent form including all the elements noted above (procedure description, risks, benefits, etc.). The product also facilitates digital signature capture on the generated form and integrates with various EHR systems. Dialog Medical maintains a library of dermatology-specific educational material and consents in English and Spanish. iMedConsent PE costs $695 for a single doctor license plus $295 for each subsequent year renewal.

While iMedConsent is a content creation tool, Systemedicus EduConsent is a content delivery system which requires that the practice already has the educational content to present with the consent forms. An iPad is used to present the medical practice’s consent documents which can include not only text, but also photos, illustrations, graphics, charts, and videos. Different versions of text can be accessed by the patient, based on the patient’s level of education, age, and preferred language. The size of the font can be adjusted for increased legibility or a text-to-speech mode can be used. Basically, the system has features to deliver the consent education in an easy-to-read and comprehensible a manner as possible.

The most important feature of the system is called “comprehension checkpoints.” This feature tests a patient’s level of understanding via a series of questions. Correct answers are recorded by the system and the patient is allowed to read on to the next section. Incorrect answers redirect the patient to the relevant information and the patient is given another chance to answer the question. The entire process is time and date stamped and recorded on video. Page turns are timed, and educational videos cannot be fast forwarded or skipped.

After the patient completes the education process, the physician is also recorded on the video, asking the patient if he or she has any questions about the procedure thereby documenting the entire doctor-patient interaction. Thus, an indisputable record is produced as evidence that a full informed consent process was concluded. The patient signs the consent with a digital signature and a PDF of the consent is emailed to the patient and the physician. The medical practice then saves the signed consent in the EHR. EduConsent is licensed on an annual basis and pricing depends on how much customization is required.

OTHER AREAS WHERE CONSENT IS NEEDED
In addition to the requirement for informed consent before a medical procedure, consent forms are used for other purposes in a medical practice.

Consent for use of the patient portal
Stage 2 of Meaningful Use requires that at least 5 percent of patients view, download, and transmit their health information and send a secure electronic message to their provider. To comply with this patient engagement requirement of Meaningful Use, physicians might offer their patients the opportunity to access their health records through a patient portal. This is typically a module provided by the EHR system. It permits the patient to view clinical treatment information, request an appointment, and to securely communicate with the physician or the medical office staff.

According to HealthIT.gov, it is not required to have the patient sign a consent to use the portal. However, it is advisable to have the patient read the policies and procedures for use of the portal and to sign a document, often called informed consent, acknowledging the risks of using the portal and agreeing to its appropriate use.

Consent for health information exchange
Meaningful Use Stage 2 requires that doctors electronically share summary of care information when referring a patient to another provider. Generally, this electronic sharing will be via the use of a health information exchange or HIE. Patients are asked to sign consent to allow their health care provider to view their health information that is shared on the HIE, a topic I covered last year; see www.aad.org/dw/monthly/2013/october/health-information-exchanges.

Based on state laws and the requirements of each HIE, consent may be requested before a physician can share or view a patient’s information via an HIE.

HHS launched a site in September 2013 known as Meaningful Consent, which “addresses the laws, policies, and issues related to the electronic exchange of health information.” The resources educate patients regarding whether to share their medical information via an HIE.

CONCLUSION
Informed consent is a process requiring education, a signature, and documentation. This benefits both the provider, by limiting liability, and the patient, by setting expectations and thereby improving satisfaction. Automating the consent process can reduce the risk of litigation in malpractice claims which arise from the discrepancy between the patient’s expectations and the outcome of the treatment. Technology is available to enable medical practices to implement a consent process which provides a high level of education insuring that patients are indeed informed, and creates indisputable evidence of consent all in an automated and efficient manner.

This article is not intended to provide legal advice or to define a procedure for obtaining consent. dw
The most rewarding thing about being a dermatologist is: (check all that apply)

- Using my medical expertise to make a difference
- Seeing the joy on patients' faces
- Learning about new treatments
- Educating patients about skin cancer
- Helping people feel better about their appearance
- Waiting months for patients to pay for my expertise and care
- ____________________________

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Record retention

HOW LONG SHOULD YOU KEEP YOUR RECORDS?

EACH MONTH, DERMATOLOGY WORLD tackles issues “in practice” for dermatologists. This month Rachna Chaudhari, the Academy’s practice management manager, offers tips on an area she commonly receives questions about from members.

BY RACHNA CHAUDHARI

One of the most common questions the practice management division at the Academy receives is how long a practice should keep its medical records. In addition to medical charts, practices need to be aware of retention requirements for other records — mainly business, legal, and financial documents.

HOW LONG SHOULD I STORE MY MEDICAL CHARTS?

Most practices face this predicament when storage becomes an issue. How long you are required to store your medical charts often depends on your individual state’s law as well as your malpractice carrier’s guidance. For an overview on each state’s law on record retention requirements, visit www.healthit.gov/sites/default/files/appa7-1.pdf. You should also contact your individual malpractice carrier to determine if they have additional requirements in order to maintain your malpractice coverage.

If you are facing a storage problem, you may want to consider scanning your charts and storing them on a server. This would allow you to shred your paper charts and maintain only electronic copies for those records that are not needed on a more frequent basis. (All paper charts should be shredded prior to disposal to ensure the privacy of protected health information). There are many vendors who would also perform this service for your practice; however you would need to follow appropriate HIPAA guidelines to ensure a breach of confidential information does not occur. This would include signing a business associate agreement with the vendor since they may have access to protected health information.

DO I NEED TO STORE ANY FINANCIAL STATEMENTS THAT CORRESPOND WITH MY MEDICAL CHARTS, I.E. EXPLANATION OF BENEFITS FORMS, CLAIMS, ETC.?

Yes, you must store these documents as they note your financial transactions for tax purposes. The Internal Revenue Service (IRS) requires that you maintain these records for at least seven years; however, the False Claims Act, a federal law that can hold a physician liable for defrauding the government, has a statute of limitations of 10 years. Thus, it is prudent to maintain these financial records for
at least 10 years if you are participating in the Medicare program. Additionally, if your private payers have their own regulations concerning audits, you should maintain those financial records for their recommended amount of time. Many states have regulations concerning look-back timelines for payers, which would limit your retention time for these documents.

ARE THERE ANY REQUIREMENTS TO STORE EMPLOYMENT RECORDS?
The U.S. Equal Employment Opportunity Commission (EEOC) requires that all employers keep personnel records for a minimum of three years. Any financial documents associated with employment, such as payroll forms, benefits paperwork, etc., should abide by IRS regulations. If there is an OSHA hazard or other issue with an employee, it would be wise to keep those personnel records for a longer period of time as any workplace injury or performance issue could have long-term implications.

WHAT IF I HAVE AN ELECTRONIC HEALTH RECORD (EHR)? DO I NEED TO KEEP ANY PAPER RECORDS?
If you have an EHR in your office, you do not need to keep any paper charts on file as all your medical records are maintained electronically. There is no requirement to have a redundant storage system in place, but records should be retained electronically for the same amount of time as they would be required to be retained in paper form. Additionally, if you have a practice management system, you do not need to keep paper copies of your financial forms since most of your claims would be recorded in the system.

For additional guidance on record retention requirements, please consult the following table, reprinted from the AAD’s Starting and Marketing a Practice manual with permission from Daniel M. Bernick, Esq., MBA. Bernick is an attorney and consultant with the The Health Care Group, Inc. and Health Care Law Associates, P.C., in Plymouth Meeting, Pennsylvania. dw

<table>
<thead>
<tr>
<th>TYPE OF RECORD</th>
<th>MINIMUM RETENTION TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>Patient charts</td>
<td>Forever *</td>
</tr>
<tr>
<td>Medical correspondence (to patients, to referrers about patients, etc.)</td>
<td>Forever *</td>
</tr>
<tr>
<td><strong>BUSINESS RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>Day sheets, patient billing or fee slips and other original entry items</td>
<td>10 years</td>
</tr>
<tr>
<td>Internal monthly summaries, management reports and interim financial reports</td>
<td>3 years</td>
</tr>
<tr>
<td>Internal year-end financial and management reports</td>
<td>7 years</td>
</tr>
<tr>
<td>Accountants’ annual financial reports and underlying schedules, work papers, etc.</td>
<td>Forever **</td>
</tr>
<tr>
<td>Third-party insurance claims, records and correspondence</td>
<td>10 years</td>
</tr>
<tr>
<td>Purchase invoices and paid bills</td>
<td>7 years</td>
</tr>
<tr>
<td>Business correspondence:</td>
<td></td>
</tr>
<tr>
<td>a) Routine, low importance</td>
<td>1 year</td>
</tr>
<tr>
<td>b) General</td>
<td>3 years</td>
</tr>
<tr>
<td>Major legal and important matters</td>
<td>Forever</td>
</tr>
<tr>
<td>Expired insurance policies (except malpractice)</td>
<td>3 years</td>
</tr>
<tr>
<td>Malpractice insurance policies</td>
<td>Forever</td>
</tr>
<tr>
<td>Insurance records, current claims reports and related materials</td>
<td>Forever</td>
</tr>
<tr>
<td><strong>BANKING RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>Duplicate deposit slips</td>
<td>1 year</td>
</tr>
<tr>
<td>Canceled checks (except as below)</td>
<td>7 years</td>
</tr>
<tr>
<td>Canceled checks for major items including: taxes, major asset purchases, real estate improvements, special contracts, etc. (to be filed with papers for the underlying transaction)</td>
<td>Forever</td>
</tr>
<tr>
<td>Monthly bank statements</td>
<td>1 year</td>
</tr>
<tr>
<td><strong>EMPLOYMENT RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>Applications (except of employees actually hired)</td>
<td>3 years</td>
</tr>
<tr>
<td>Personnel records (including original applications) after termination</td>
<td>3 years</td>
</tr>
<tr>
<td>Payroll records and summaries, including payroll tax forms</td>
<td>7 years</td>
</tr>
<tr>
<td>Employee time sheets and/or time clock records</td>
<td>7 years</td>
</tr>
<tr>
<td><strong>TAX RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>Tax returns and any documents relating to tax audits and adjustments</td>
<td>Forever **</td>
</tr>
<tr>
<td>Worksheets, lists, schedules, etc., supporting tax return items - generally</td>
<td>7 years</td>
</tr>
<tr>
<td>Documents, receipts, worksheets, etc. as to property (real estate, stocks, bonds, tax shelters, etc.) no longer owned</td>
<td>Keep until property is disposed of plus 7 years</td>
</tr>
<tr>
<td><strong>LEGAL DOCUMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Deeds, mortgages and bills of sale of major items</td>
<td>Forever</td>
</tr>
<tr>
<td>Partnership agreements, corporate employment/shareholder agreements, etc.</td>
<td>Keep permanently until expired, then 7 years</td>
</tr>
<tr>
<td>Corporate minute books, charter bylaws and minutes</td>
<td>Keep until you cease being a shareholder plus 7 years</td>
</tr>
<tr>
<td>Promissory notes receivable and other documents of debt owing to you</td>
<td>Keep until fully paid plus 7 years</td>
</tr>
<tr>
<td>Original promissory notes which you have paid off - unless returned and marked “Paid”</td>
<td>Forever</td>
</tr>
<tr>
<td>Copies of promissory notes payable payment schedules and records of debts you owe</td>
<td>3 years after full payment</td>
</tr>
<tr>
<td>Canceled stock and bond certificates</td>
<td>7 years</td>
</tr>
</tbody>
</table>

* Unless otherwise advised by your local attorney based on review of state rules regarding chart maintenance and statute of limitations on malpractice lawsuits.

** There are various time constraints on the ability of the IRS to assess taxes after a return has been filed. However, there is no time limit on assessment for returns not filed, and without a copy, you cannot prove that a return was in fact filed. It is also advisable to retain tax and financial records for purposes of establishing tax basis in assets that are later sold.
CAPITOL BATTLE
DERMATOLOGY’S AGENDA AWAITS ELECTION OUTCOME
As the November elections draw near, polls show Republicans within striking distance of taking control of the Senate. If that occurs, it may ease some of the gridlock that the current Congress is experiencing. However, it may not be enough, under a Democratic president, to pass legislation of importance to dermatology.

Of the 36 U.S. Senate seats up for election in 2014, 21 are currently held by Democrats and 15 are held by Republicans; Republicans need to win six additional seats to gain control of the chamber. (All 435 seats in the U.S. House of Representatives are up for election, but Republicans are expected to easily retain control; there are also 39 races for governor.) The real question is whether a congressional shift in power would impact some of dermatology’s priorities — including teledermatology, pathology billing, indoor tanning, and payment reform — any differently. Overall, many of these issues are viewed as bipartisan. >>
“Whether the legislators are Republicans or Democrats, they’re going to look for things that will save money or be budget neutral,” said Jane Grant-Kels, MD, co-chair of the Dermatopathology Rapid Response Committee of the American Academy of Dermatology Association (AADA). “I don’t think it matters which party gets in because the Affordable Care Act (ACA) is here to stay,” added Dr. Grant-Kels.

Hazel Konerding, MD, chair of the AADA’s political action committee, SkinPAC, is hopeful that a Republican-led Congress may end some of the current obstruction. “But even if the Republicans control the Senate, they’re not going to have enough votes to override a presidential veto. So for practical purposes, I’m not sure it’s going to speed up the way anything gets done,” she said, adding, “Our best hope is to persuade people to do the right thing no matter which political party they belong to. That seems to be an uphill fight at the moment.”

Despite the AADA’s priorities being considered bipartisan, there is concern that they may get swept up in the politicization of Obamacare. To the extent that one party is not enamored with the ACA, anything to do with additional health care legislation might be perceived as an extension of the ACA and rejected on that basis, noted Murad Alam, MD, chair of the AADA’s Health Care Finance Committee and co-chair of its Dermatopathology Rapid Response Committee.

**TELEDERMATOLOGY**

Telemedicine has been gaining political popularity in recent years as a means to increase access to care for the millions of individuals expected to be covered under the ACA. However, Sabra Sullivan, MD, PhD, chair of the AADA’s Congressional Policy Committee, pointed out that the Academy has been trying to move telemedicine forward for more than a decade. Well-suited to dermatology because it’s a visual specialty, the AADA agrees that telemedicine would help meet the needs of underserved communities across the country.

“Everyone agrees that telemedicine is a good thing in the appropriate circumstances,” said Dr. Alam, who is also co-chair of the AADA’s Telemedicine Reimbursement Advocacy Workgroup. “Preliminary research suggests that it can be used effectively without compromising quality of care in certain circumstances.” The concern is that telemedicine will be pushed through solely as a cost-savings mechanism without consideration for appropriate use. “We really have to scrutinize the details of any legislation to make sure that well-intentioned policymakers are not doing something that could ultimately cause problems with patient safety, access to care, or adequate resource allocation,” he said. For example, access to face-to-face dermatology appointments should not be restricted simply because teledermatology becomes viable.

Dr. Grant-Kels believes that Democrats would be more amenable to looking at teledermatology because of its potential to lower health care costs. But before teledermatology can become more commonplace, state licensure issues, liability concerns, reimbursement mechanisms, and appropriate coding all must be addressed, Dr. Sullivan said.

The Interstate Medical Licensure Compact proposed by the Federation of State Medical Boards (FSMB) could lift licensure restrictions. Under the compact, qualified physicians would be eligible for expedited licensure in all participating states. While participating state medical boards would retain their licensing and disciplinary authority, they would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders. “The Republicans would probably back the FSMB compact as long as the states’ rights were preserved,” Dr. Grant-Kels said. A Democratic Senate, however, might push for a national license solution as opposed to keeping control at the state level. In January, a bipartisan group of 16 senators commended FSMB for its efforts to streamline the licensing process.

There is still the issue of liability that has yet to be addressed either by new legislation or the ACA. States with Republican governors seem to address liability concerns more than those with Democratic governors, Dr. Grant-Kels said. For example, Texas has eliminated a lot of pain and suffering liability, which she points out is very subjective. Physicians aren’t going to provide telemedicine if they are not covered for malpractice or reimbursed appropriately, Dr. Konerding said. Currently, most states do not require reimbursement for telemedicine. Will a federal law need to be passed allowing physicians to join other states’ insurance networks or would telemedicine
services be provided on a contractual basis? In order to receive appropriate reimbursement, coding will have to be developed for telemedicine services, as well. The Academy, through its representatives on the AMA CPT Editorial Panel, is working to develop CPT codes for teledermatology, but that process, including gaining approval of valuations by the Relative Value Scale Update Committee, or RUC, can take a couple of years, Dr. Sullivan noted.

Additionally, the advancing technology needs to be addressed, Dr. Alam said. To date, telemedicine has been delivered based on a patchwork of rules and regulations that have sprung up over time and have not always kept up with the technology as it has evolved. “There is a regulatory framework,” he said, “but it needs to be refined.” Dermatologists can play a role in providing guidance during the process, Dr. Alam suggested, a role the AADA has played by developing a more comprehensive position statement; see p. 42.

“The last thing we want is federal intervention to address these issues,” Dr. Konerding added. She believes that state medical boards should address licensure restrictions, the insurance industry should figure out the reimbursement issue, and so on.

PATHOLOGY BILLING

Federal legislators are examining repeal of the in-office ancillary exception to the federal Stark law that governs physician self-referral. This may be particularly attractive to the party that wants the ACA to succeed, Dr. Alam noted, but members of either party may focus on this more as funding streams contract. Dr. Alam is concerned that dermatologists need to keep reminding legislators that while cutting costs is important, it shouldn’t be achieved on the basis of eliminating services that are actually necessary. The ACA, while well intentioned, has created some unfunded mandates and money has to be found to pay for them, he continued. The newly insured need services but government’s budget is stretched and the economy isn’t growing quickly enough to eliminate deficits.

Both parties could view physician self-referral as abuse per the July 2013 Government Accountability Office report that found dermatologists, as well as urologists and gastroenterologists, refer more pathology cases to their in-house labs than they had been to outside reference labs prior to running their own labs. “It’s important for the AADA to stand firm in protecting dermatologists’ rights to read their own slides, supervise their labs, or choose a dermatopathologist to interpret their slides if they choose not to do it themselves,” he said. To that end, dermatologists have to convey their value to policymakers so the latter understand the additional training, expertise, and time required to interpret slides in a manner that is most helpful for establishing a diagnosis and guiding treatment.

Dr. Konerding would be surprised if Republicans moved to rescind the exception because they have generally supported it. However, an egregious case related to self-referral labs that makes national headlines might prompt

DERMATOLOGY’S ISSUES...IN POLITICAL TERMS

How will the upcoming election affect priority items on dermatology’s legislative agenda?

TELEDERMATOLOGY: Democrats are interested in its potential to lower costs. Republicans are more inclined to address medical liability issues raised by the practice.

PATHOLOGY BILLING: Democrats have proposed tightening self-referral restrictions to save money; Republicans have not yet supported such efforts.

INDOOR TANNING: Democrats have been more inclined to regulate the tanning industry, but Republican governors have also signed age-restriction legislation.

PAYMENT REFORM: Both parties agree that the Sustainable Growth Rate formula is broken and needs to be addressed; they also see payment reform as a vehicle to move the health care system away from fee-for-service.
them to do so. “If the Stark exemption was removed by Congress, I suspect the president would sign it even if it was a Republican Congress that did it,” she added.

INDOOR TANNING
The Republican support of small business that works in dermatologists’ favor when it comes to the Stark exception could potentially work against them with regard to indoor tanning, but it’s unlikely. Everyone is recognizing the dangers of indoor tanning, noted Kelley Pagliai Redbord, MD, chair of the AADA’s State Policy Committee. “It’s a white hat issue to protect our minors from skin cancer and sunburn.”

Despite some Republicans having been critical of the indoor tanning tax and Democrats generally having been supportive, Dr. Sullivan pointed out that when Mississippi, where she practices, passed an indoor tanning bill it was signed by the Republican governor.

“Despite some Republicans having been critical of the indoor tanning tax and Democrats generally having been supportive, Dr. Sullivan pointed out that when Mississippi, where she practices, passed an indoor tanning bill it was signed by the Republican governor.”

PAYMENT REFORM
Whether it’s repealing the Sustainable Growth Rate payment formula or advocating for reforms that preserve fee-for-service for those specialties that do not fit into the new payment models being considered, payment reform is not expected to move quickly no matter who sits in Congress because of disagreements among congressional leaders about how or whether to offset the cost of reform.

Dr. Alam is not convinced that one party cares more about payment reform than the other. Republicans tend to be more capitalistic and fee-for-service is a capitalistic form of payment. But Republicans are also concerned about the impact of rising employee health costs on businesses, he said, and if significant financial relief to small and large businesses could accrue by lowering health care costs, that could catch the Republicans’ attention.

“The Democrats seem to want a single payer and they want cradle-to-grave coverage whereas Republicans are probably more in favor of market-based solutions, such as the Medicare Advantage plan, and would incorporate more individual responsibility and higher deductibles,” Dr. Grant-Kels added. “Those are the major differences between the parties, but those are minor tweaks to a system that has already been markedly altered because the capitalistic system of private practice is going by the wayside.”

Dr. Alam concurs. “Regardless of who is in control, we are moving away from fee-for-service,” he said. There is a bipartisan perception that fee-for-service is bad because it has incentivized too much health care, but Dr. Alam notes that systems that have low incentives for physician productivity may result in too little health care. “Fee-for-service might last longer than some think because even the most fervent opponents of it have failed to come up with a workable alternative,” he added.
Sylvia Matthews Burwell received a bipartisan show of support for her nomination as the 22nd Secretary of Health and Human Services (HHS). Although 24 Republicans joined with Democrats to approve her nomination by a 78-17 Senate vote, some Republicans did not support her confirmation, perhaps to demonstrate their lack of support for the health care law that she will be responsible for implementing further.

On Burwell’s to-do list are completing the automatic re-enrollment on www.Healthcare.gov and addressing other technical issues with the website; merging three failed state exchanges and possibly more into the federal insurance exchange; and addressing the requirement for employers offering health benefits to their workers, a provision that has been delayed twice.

Much has been made about Burwell’s ability to garner bipartisan support in her most recent post as director of the Office of Management and Budget. “We hope her ability to work with individuals on both sides of the aisle will continue,” said Sabra Sullivan, MD, PhD, chair of the AADA’s Congressional Policy Committee.

Murad Alam, MD, chair of the AADA’s Health Care Finance Committee, noted that Burwell has a reputation for being an effective administrator, which could be a double-edged sword. “I’m assuming she will vigorously support the administration’s plans and preferences,” he said. “But there are things that we don’t like, elements of the ACA and health care reform that have not been properly worked out, that might be expedited.” The Obama administration doesn’t want another fiasco, Dr. Alam said, referring to the faulty roll out of the ACA website led by the former HHS Secretary Kathleen Sebelius, who helped oversee the health care overhaul through Congress during Obama’s first term. Burwell was specifically selected for her ability to implement complex rules and regulations, and she will likely have more political capital to push them through, he said. “President Obama has a lot at stake with the ACA in terms of his legacy,” Dr. Alam added. “The post-election regulatory environment will be affected by how aggressively the president presses his agenda, how efficiently HHS functions, and how the composition of Congress changes. As physicians we can work with whichever legislators from whichever party who are sympathetic to our mission of providing the safest, most effective, and most affordable care for our patients.”

Dr. Sullivan pointed out that all politics is local. “Before your senator or representative goes to the Hill, he or she is in your district first,” she said. “For as much conflict and turmoil as we’ve had in the past few years, we’ve seen a lot of progress made through our contacts with legislative groups.” Several members of Congress and numerous committees have sought dermatologists’ opinions on issues such as teledermatology. Many times, they are unaware of the issues involved and will listen to others’ opinions and incorporate them. “So regardless if the Republicans or Democrats have control of the Senate after the 2014 elections, we still have that,” Dr. Sullivan said.

With these issues being largely bipartisan, it may take the next presidential election to move them significantly forward. “I think the big shift will come in 2016,” Dr. Sullivan said. “We’ll see what happens under a new president.”

In the meantime, Dr. Redbord encourages dermatologists to get to know their newly elected senators and representatives. “Developing relationships with the new legislators enables us to serve as a resource for them and also have their ear when issues important to dermatology arise,” she said. “We can have a voice for dermatologists if we have friends on the Hill.”
BRIDGING
the cultural divide
Cultural competence isn’t a new concept in medicine, but it’s gaining prominence as many, if not most, physicians see increasing diversity among their patients. Amit G. Pandya, MD, professor of dermatology at the University of Texas Southwestern Medical Center, sought cultural competency training and resources from the American Association of Medical Colleges, which now mandates such training for accreditation of medical schools. He now gives presentations on the topic at medical meetings and to medical students at UT Southwestern. “I think we have a deficiency in cultural competence training not just for students and residents, but also for practicing physicians,” he said. “And that’s going to be more of a problem in the future because the U.S. is changing so rapidly that it’s thought that by 2030, half of the population will be Hispanic, African-American, or Asian. We must face these issues around culture in medicine.”

The issues range from the obvious, such as a patient’s limited proficiency in English (see sidebar, p. 30-31), to those that may be more difficult to discern, such as traditional beliefs associated with a particular disorder in a patient’s country of origin. Lack of cultural competence can contribute to disparities in access to health care among certain groups, and can also have a negative impact on the physician-patient relationship, Dr. Pandya said. “I sometimes have patients who have come from other physicians, both dermatologists and non-dermatologists, and because I speak Spanish, or I’m aware of their culture, I realize that the other physician likely missed an important detail in their interaction with the patient that would have improved compliance and given a more positive outcome.” His key message, echoed by other dermatologists who treat a diverse group of patients: educate yourself about the cultural background of the patients you’re most likely to encounter, but don’t let that knowledge drive assumptions about an individual patient; ask that patient about his or her concerns.>>
THE TOUCHY TOPIC OF HAIR
“In general, hair is a very touchy subject for African-American women, and some dermatologists are not familiar with common hair care practices,” said Temitayo Ogunleye, MD, an assistant professor of clinical dermatology at the University of Pennsylvania School of Medicine. “The texture of hair in the African-American community is so varied that everyone has a different hair care practice that works for her. The issue for dermatologists comes when they automatically assume that it’s OK for an African-American patient to wash her hair every other day because she has seborrheic dermatitis or some other condition. They’re potentially recommending a treatment that can lead to increased dryness, brittleness, and breakage, which can worsen their issue.” She recommended that a dermatologist who isn’t familiar with African-American hair ask, “What is your hair care practice, and how often do you wash your hair?” As long as they’re washing it at least once every three weeks, I’m OK with it. In general, I find I’m able to treat people appropriately by using the hair care practices that they’re used to.” Dermatologists should also avoid making assumptions about other hair care practices, Dr. Ogunleye noted. “I’ve had a couple of patients who have been very offended because another dermatologist has assumed that they use heat or chemical relaxers or wear a weave, or wear braids,” she said. “The main cultural consideration, I would say, is always ask, never assume. When you assume the patient is doing something traumatic that’s leading to hair loss — while it may be true — it’s not fair to make that assumption about everyone. Ask what they do, and if they have questions about particular hair care practices.”

Many African-Americans seek an African-American dermatologist because “they think that person understands or knows their skin and hair better, and therefore will be able to treat them more effectively,” said Valerie M. Harvey, MD, an assistant professor of dermatology at Eastern Virginia Medical School and co-director of the Hampton University Skin of Color Research Institute. She questioned whether the “demographics of our dermatology workforce are keeping...

PLAIN SPEAKING:
WHAT WORKS AND WHAT’S REQUIRED

Clear communication between patient and physician starts with a common language. A 2012 report from American Public Media’s Public Insight Network (available online at www.publicinsightnetwork.org/2012/07/11/medical-interpreter) entitled “A right to a medical interpreter, but not a guarantee” cites 2010 U.S. census data showing that 25 million people in the U.S. “don’t know enough English to get them through a routine hospital or clinic visit,” and that the number has increased by 80 percent in the past 20 years.

A simple conversation with a patient can tell a physician a lot about that patient’s mastery of English, said Amit G. Pandya, MD, professor of dermatology at University of Texas Southwestern Medical Center. “The first step in a cultural assessment should be to determine if the patient speaks English or not, and if they do speak it, can they read it; do they seem to have a good familiarity with it?” If not, “it’s always a good idea to make sure that whatever information you give them is also given in their language. For Spanish-speaking patients, for example, the AAD and the American Academy of Family Physicians [at www.familydoctor.org] provide a wealth of patient education materials in Spanish.”

Fluent in Spanish and Gujarati (one of India’s official languages) as well as English, Dr. Pandya can communicate directly with his Latino patients who have limited proficiency in English. Dermatologists who aren’t multilingual have a range of other options. “If a family member calls to make an appointment and it’s made clear that the patient doesn’t speak English, our call center will try to make sure that an in-person translator is available for the visit,” said Temitayo Ogunleye, MD, assistant professor of clinical dermatology at the University of Pennsylvania School of Medicine. “However, if we don’t catch that in advance, we do have a phone interpreter service we can use. The department pays for that, as far as I know. For a small or private practice, it may not make sense to pay for an interpreter or a service that’s on call if they don’t see a large population of patients who don’t speak English.”

Dr. Pandya remarked that only an adult family member or friend — not a child — should serve as translator, and the dermatologist should feel comfortable with the interactions between translator and patient, and translator and dermatologist. “Sometimes what’s coming out of the translator is not what the dermatologist...
pace with the demographic shift that we’re seeing naturally. If people seek a dermatologist who looks like them, can we provide that? These are interesting issues that have not received a lot of attention in our discipline compared to other medical disciplines.”

**PIGMENTATION DISORDERS**

For dermatologists, treating patients from diverse ethnic and racial groups means grappling with pigmentation disorders that may strike at the very core of the patient’s identity and self-esteem. “The major issues for patients of color are complaints about pigmentation, whether it’s hypop- or hyperpigmentation,” said Dr. Ogunleye. “I don’t think there’s much difference between immigrants and U.S.-born patients except in the practice of skin-bleaching, which is much more heavily practiced in Asian countries, in India, and in different parts of Africa. It stems from issues of colorism, the idea that being lighter-skinned is associated with different social advantages such as being perceived as prettier, getting better jobs, or making more money.”

Melasma, in particular, can be devastating to Asian patients and others with medium dark skin, said Lenore Kakita, MD, an emeritus clinical professor of dermatology at UCLA who was a private practitioner in Los Angeles for many years and is now retired in Las Vegas. “Asians may be very quiet about it, though very upset; it can truly lead to a loss of self-esteem,” she said. “In the Asian population, a very fair, even-toned skin reflects signs of purity, elegance, prominence, and beauty. So when you start getting brown blotchiness of the face, there is great disdain and often shame.” That said, hyperpigmentation was a concern for her Caucasian patients as well, “and the issues emotionally are the same for all.” While her Asian patients were quite receptive to advice about sun protection, some patients purchased skin-lightening products thought to contain mercury in ethnic markets in Los Angeles, Dr. Kakita said, and dermatologists should be aware that patients may be seeking dangerous remedies to bleach their skin.

Prior to implementation of the Affordable Care Act, legislative rules relating to interpreter services for patients with limited English proficiency (LEP) resulted from Title VI of the 1964 Civil Rights Act, which prohibits discrimination based on national origin. (See www.aad.org/dw/monthly/2012/february/complying-with-the-law-while-treating-patients-with-special-needs-for-an-explanation-of-what-constitutes-Title-VI-compliance-for-both-larger-hospital-based-systems-and-smaller-providers.) The rollout of the ACA extended previous mandates and created new provisions designed to allow LEP individuals full access to the health care system. In “A Quick Primer on Affordable Care Act Language Service Requirements,” [available online at www.languagescientific.com/language-services-blog/affordable-care-act-language-service-requirements.html], Jessica McGowan, marketing manager of Language Scientific, a medical and technical translation company, explains how the ACA builds on both Title VI rules and those associated with an executive order signed by President Bill Clinton in 2000 that requires all federal agencies to provide LEP individuals with meaningful access to their services. Key points include:

- **Title VI** covers all health care institutions and programs receiving federal aid, as well as health insurance plans set up under the ACA.
- The ACA’s Section 1331 states that patient communication must be given in “plain language” so that “the intended audience, including individuals with limited English proficiency, can readily understand and use” the information.
- Section 1001 of the ACA mandates that “health insurance companies and group health plans use language that is linguistically and culturally appropriate when communicating with insurance enrollees.”
- The threshold for providers and insurers to provide translation for LEP patients is reached when “10 percent or more of the population living in the consumer’s county are literate only in the same non-English language.”
At the other end of the spectrum, vitiligo can be equally devastating, and not just for very dark-skinned patients. “Regarding vitiligo, I’m learning more and more about cultural differences that influence perceptions of their disease,” said John E. Harris, MD, PhD, dermatologist and assistant professor of medicine at the University of Massachusetts Medical School. “The first thing most people assume is the darker the skin, the worse it is to have vitiligo because it’s more obvious. Although that's partially true, it’s more nuanced than that.”

In speaking with the director of Vitiligo Support International, a Caucasian and a vitiligo patient herself, Dr. Harris “mentioned to her that I felt it was more of a concern to darker-skinned people, and she was indignant. She wanted me to recognize very clearly that Caucasian patients may suffer just as much, psychologically.”

Among ethnic groups with darker skin, “you may think that Africans, Indians, and Middle Easterners would be the most concerned,” Dr. Harris remarked. “But in addition to skin color, cultural issues within each country make a huge difference. I don’t want to generalize too much, but I feel like my Indian patients are the most stigmatized by their vitiligo. Why? I think that arranged marriage may strongly influence this cultural stigma.” Being healthy, without disease, is a key issue as parents select a spouse for their child, he pointed out, and a candidate who does not have an obvious skin disorder has an advantage over one who does. Another factor underlying the stigma may be that vitiligo looks somewhat like leprosy to their peers, though to a trained dermatologist they look very different. In India, leprosy has been a deep, longstanding problem. “In a similar vein, vitiligo can be associated with albinism in Africa, where albinos have been feared and terribly mistreated, even killed,” Dr. Harris said. “Africans with vitiligo here in the U.S. may not worry that they’ll be murdered, but there’s still this idea that if you’re black and turning white, it’s a whole person change and can be very hard to deal with because they feel as if they don’t fit in anywhere.”

Dr. Ogunleye consulted Dr. Harris about a teenaged patient with vitiligo so severe that he requested depigmentation therapy that would uniformly lighten his skin. “He’s a darker-skinned Italian, and this is the first time I’ve been in this situation with a patient so young,” Dr. Ogunleye said. “I’m trying to get him in touch with people who have had this therapy. It’s one of those things that has to be approached very sensitively, and I think that patients who go through this have to be aware of not just the practical aftereffects but also the cultural and social ramifications. You might be treated differently by your family members, and there might be some backlash from people who think you’re trying to be lighter.”

A famous example is Michael Jackson, she pointed out, “who was reported to have vitiligo and also reported to have depigmented his skin as a treatment for it. He got a lot of backlash from people who thought he was trying to be white.”

Dr. Harris advised dermatologists seeing a patient with vitiligo to “not make any assumptions based on skin color. Let your patient tell you how much it bothers them. I’ve had patients come to me who have been dismissed by other doctors who say vitiligo isn’t that big a deal, and they’re devastated by the interaction. Studies have shown that vitiligo, eczema, and psoriasis aren’t very different in terms of their negative effects on quality of life.” In addition, “in order to take cues from your patients, you need to be aware of cultural differences. Imagine if you thought you could never be married. People commit suicide over this.”

**CULTIVATING CULTURAL COMPETENCE**

Dermatologists can take an important step toward achieving cultural competence by immersing themselves in the cultures they live with, Dr. Pandya said. “Read a best-selling book about the cultures in your area, watch movies about important issues in the societies your patients come from. Go to cultural fairs that highlight traditions, dance, food, and dress,” he suggested. “Volunteer at local teaching hospitals and free clinics. If you’re in a community with lots of Vietnamese patients, volunteer for a short-term medical trip to Vietnam.” Though it may not be feasible to become fluent in multiple languages, “I tried to learn how to say hello, goodbye, and thank you in 15 or 16 different languages spoken by my patients. The patient really appreciates that you’ve taken the time to learn that.”

In individual patient encounters, cultural assessment should begin with a determination of the patient’s proficiency in English, Dr. Pandya said. Next, “find out the family location, their support system, and who are their advisors. Are they here by themselves? Do they get advice from people who know about the society here? Also, are there financial barriers that prevent them from adhering to a treatment plan? They might be reluctant or ashamed to tell you that, so one needs to gently prod and find out.” Cultural beliefs regarding health, such as the belief that an illness constitutes a moral judgment, can also be a barrier to treatment, as can traditional health practices. “Sometimes what people do in terms of folk remedies, practiced by elders and folk healers, can be so unbelievable that you feel like raising your eyebrow or even laughing, but one has to be careful not to do that because they may be important to the patient,” Dr. Pandya said. “If they bring this up, try in a kind way to explain the approach of evidence-based medicine.” Also, understand that “some patients may come from a society where there’s less independence, and that decisions may actually be made by someone in the family or a community or religious leader. That’s especially important for patients from Eastern societies, where the needs of the individual may not outweigh the needs of the community.”

Cultural competence is “central to professionalism, and that should include humility, empathy, curiosity, respect, sensitivity, and awareness,” Dr. Pandya said. Dermatologists should keep in mind that “patients come in with their own experiences and expectations; we should be sensitive to those issues, and reassure them that we’re willing to learn and understand the cultural component of their disease so we can better treat them,” Dr. Harvey said. “As in any other medical discipline, treating patients goes beyond the medications we give them — it’s a lot about making that connection.”
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TREATING WOUNDED WARRIORS

ADVANCES IN MILITARY DERMATOLOGY IMPROVE OUTCOMES FOR SOLDIERS, VETERANS
As U.S. service members battle on many fronts all over the globe, military dermatologists are breaking ground on new ways to help these men and women recover when they are wounded.

“It’s only been in approximately the last five or six years that we’ve had a seat at the table in the realm of trauma rehabilitation,” said Cmdr. Peter Shumaker, MD, chairman of dermatology at the Naval Medical Center in San Diego. “I think dermatologists have a lot to offer people who have suffered severe traumatic injuries, and military dermatologists have had an important role in introducing breakthrough treatments for scars, especially ablative fractional laser resurfacing.”

Dr. Shumaker and his colleagues recently published a review demonstrating the value of laser treatment, especially fractional ablative laser treatment, in treating scars in *JAMA Dermatology* (2014;150:187-193). The article suggested that the potential benefits of lasers for scar treatment have not been realized yet and recommended integrating fractional resurfacing into future scar treatment paradigms. >>
While attuned to the cost of care, military dermatologists are generally free of the burden of considering insurance reimbursement when making treatment decisions. “In addition to the responsibility to offer our wounded warriors the best possible care, this is one important factor to explain why dermatologists in the military have been at the leading edge of these recent breakthroughs,” Dr. Shumaker said. “Procedures like laser hair reduction and fractional laser resurfacing have traditionally been perceived as strictly cosmetic and therefore not reimbursable in the civilian world. Our experience suggests that these procedures can be an important component of functional recovery, and I am confident they will be more widely available when perception catches up with research.”

TRAUMA REHABILITATION
Numerous military researchers are studying lasers in scar revision and care. The primary focus is not only restoring the appearance of the skin — or form — but also the function of the damaged tissue, said Lt. Col. Chad Hivnor, MD, a member of the U.S. Air Force Reserve who is working with wounded warriors during reserve duty at the 5th Medical Wing’s Wilford Hall Ambulatory Surgical Center in San Antonio.

In this effort, unique psychological aspects arise in contrast to those in civilian settings. Some wounded warriors prefer to keep their scars as badges of honor, unlike civilians who have sustained other injuries, Dr. Hivnor said. Furthermore, as wounded warriors work to regain function, they often have a single focus. “A lot of times in the military, what some of these guys want is to get back out there with their friends and fight the fight,” Dr. Hivnor said. “So that’s one of the most important things that we can do is restore the function.”

Dermatologists are treating hypertrophic or hyperemic scars with fractionated CO₂ lasers and obtaining outstanding results in decreasing the thickness, itching, and pain of the scars. Thick scars at the stump site of amputated limbs can be very painful at pressure points, said Col. Todd Kobayashi, MD, of Lackland Air Force Base in Texas. “So we treat those areas with multiple different modalities. Besides the CO₂ laser, we have a pulsed dye laser that we use,” he said.

Dr. Kobayashi explained that the Air Force has several research protocols in progress. One is exploring the use of CO₂ lasers in scar treatment, and another is using bovine skin models with the CO₂ laser to study scar remodeling.

Although scarred skin is tight and dry, laser treatments regenerate the tissue so that it is healthier, Dr. Hivnor said. “What we’re doing with the fractionated laser is that we’re almost hitting the reset button on the computer. We’re helping the skin become more normal,” he explained. Research by Ozog and colleagues published in *JAMA Dermatology* in 2013 demonstrated that treatment with a fractional CO₂ laser improved collagen architecture and the appearance of mature burn scars (149:50-57).

Furthermore, Dr. Hivnor said, Ozog’s group also reported that lasers can be used to treat postsurgical scars in *Dermatologic Surgery* (2011;37:1740-1746).

Missing limbs can create different issues for wounded warriors, and complications can be long-lasting. Lt. Col. Jon Meyerle, MD, assistant professor in the department of dermatology at the Uniformed Services University in Bethesda, Maryland, and his colleagues have researched stump dermatoses in the amputee population. According to research they published in *Archives of Dermatology* in 2012, those having major limb amputations have skin complications more than 38 years later, so they may discontinue using a prosthesis (148:1283-1286).

Some skin naturally handles friction more effectively. Dr. Meyerle and his colleagues are conducting research on altering the identity of stump skin, thickening it so that it resembles the skin on the palms of the hands or soles of the feet to prevent skin breakdown. In a review published in the *International Journal of Molecular Sciences* this year (15:8407-8427), Dr. Meyerle and his colleagues described an approach to change skin identity. “We have an open investigational new drug application with the FDA, and we hope to start a trial, funding permitting, in the next six months to alter skin identity using autologous fibroblast therapies,” Dr. Meyerle said.

Military dermatologists are also using lasers to remove traumatic tattoos resulting from gunpowder and metals from improvised explosive devices. “We use lasers designed for tattoos to remove that foreign material or break it down so the body can clear it,” Dr. Meyerle said.

SWEAT GLAND TREATMENT
Sweat glands can create problems of over- and undersecretion. One of the most important functional objectives for some wounded warriors is restoring sweat gland function, Dr. Hivnor said. “If they can’t sweat in a normal fashion, they’re not going to be able to do things outdoors,” he said. For example, one patient with severe burns all over his body and an arm amputation could not sweat; therefore, he couldn’t work later than 10 a.m. in south Texas. “After two laser treatment sessions with the fractionated laser, he was able to work all day long because he was able to sweat again,” Dr. Hivnor said.
Conversely, at the stump site of an amputated limb, clinicians need to eliminate sweating. “In south Texas, where it gets really hot and they sweat underneath the prosthesis, it can be so much sweat that it can actually cause the prosthesis to lose suction and fall off, and so we have been using Botox® to shut off the sweating,” Dr. Kobayashi said.

Dr. Meyerle and his colleagues are beginning to use the MiraDry® system off-label to determine whether it can be used to eliminate sweating at the stump site.

TARGETING HAIR GROWTH
The proper level of hair growth can also be a problem for wounded warriors. Another way that dermatologists are improving prothesis fit is to use hair removal lasers at the stump site of an amputated limb to prevent occlusive folliculitis.

Hair may regrow underneath and through a scar. “It can be a big source of chronic infections and inflammation that drive the whole scarring process non-stop. Thus, removing that hair is vital,” Dr. Hivnor said. Conversely, restoring normal hair growth by fractionating scars to allow the normal growth to occur may provide cosmetic advantages in some scarred areas, he said.

MELANOMA RESEARCH
Like their civilian counterparts, military dermatologists are also investigating melanoma. “The military has been interested in melanoma research because it’s a disease that affects people between the ages of 20 and 40, which is the military population of interest,” Dr. Meyerle said. Therefore, he and his colleagues have been engaged in research on the incidence, diagnosis, risk factors, and treatment of melanoma in the active-duty service member population. The military has a large repository of human tissue from active duty service members which includes skin as well as blood specimens, he noted. Skin tissue is archived within military treatment centers and serum by the DoD Serum Repository into perpetuity. In addition, the DoD maintains a number of databases such as electronic medical records and personnel records. The combination of these resources have allowed Dr. Meyerle and his collaborators to generate a substantial data set on melanoma.

HUMANITARIAN EFFORTS
Military dermatologists’ work is not confined to treating wounded warriors and veterans. “I think dermatology is well-suited to a humanitarian environment because we’re one of the few specialties that can do a visual diagnosis when you may not have access to lab facilities,” Dr. Shumaker said. “And we’re well-versed in small skin procedures, something definitive that can be done for a patient in a somewhat austere setting.” Dr. Shumaker traveled to Vietnam this year as part of Pacific Partnership 2014, focusing on burn scars.

They treat the full range of patients, particularly during humanitarian missions. “The fact that the Department of Defense has two pediatric dermatologists means that regular dermatologists have to do a lot of the pediatric care,” said retired captain Neil Gibbs, MD, of the Naval Medical Center in San Diego, himself a pediatric dermatologist.

ADDITIONAL ADVANCES
Technologic progress includes teledermatology, enabling dermatologists to view conditions remotely. “The military, particularly the Army, has a robust teledermatology setup, where we provide dermatology care in austere environments like Iraq and Afghanistan and on ships and in various humanitarian venues,” Dr. Meyerle said. This functions as a force multiplier, he explained. “It’s useful because if you’re a battalion physician who has a patient down range in Afghanistan with a dermatology condition, it is difficult and risky to put that patient in a truck, an airplane, or a helicopter to have that rash looked at,” he said.

PROJECT CARE
To facilitate care of wounded warriors and monitor them long term, Project CARE (Comprehensive Aesthetic Restorative Effort), funded by the Bureau of Medicine, offers a multidisciplinary approach, coordinating the efforts of plastic surgeons, otolaryngologists, orthopedists, oral surgeons, and dermatologists. “This acts as a way where military physicians can treat wounded warriors who have suffered from battlefield or traumatic injuries and they have aesthetic or functional issues with scars,” said U.S. Navy Lt. Cmdr Philip Letada, MD, project manager for the branch of the program at Naval Medical Center Portsmouth. “It’s a way that we’re able to act as a case manager for a lot of the patients and follow them throughout their time in the military and even after they get out and in the Veterans Administration system and civilian life as well. We can ensure that their needs for their care are met in regards to their scars and that sort of traumatic injury.”

CIVILIAN SETTINGS
As military dermatologists treat the consequences of traumatic injuries, they are often faced with unique
Challenges their civilian counterparts usually do not find in their practices. However, civilian dermatologists may confront some of these situations as wounded warriors leave active duty and return home.

In addition, military personnel and veterans choosing to participate in the TRICARE Prime program may receive care at a military treatment center or Veterans Administration facility, respectively, or access a civilian provider off-base. (Congress recently passed legislation to allow more veterans to seek care outside the VA system, which could lead to civilian dermatologists seeing more wounded warriors in their practices.)

If they choose to be treated outside the system, however, they will most likely encounter reimbursement issues for laser treatments that are often considered cosmetic. "But the military — the Navy, Air Force, and Army — is working on trying to get an actual reimbursable code for civilian providers to do fractionated CO2 laser treatment of our wounded warriors, such as burn victims," Dr. Kobayashi said. In this effort, the military has partnered with the American Academy of Dermatology.

Even if civilian dermatologists need to treat unfamiliar conditions in these wounded patients, they will be equipped to deal with them, said Cmdr. Eric Belin, MD, Navy dermatology specialty leader, Naval Medical Center, Portsmouth, Virginia. "As a result of the research that we do and the publications we put out, our civilian colleagues have a much higher level of awareness of the unique issues these members face as they come back into the community," he said. "Fortunately, we are also blessed to have very high-quality dermatologic training throughout the United States in our residency programs, and so while these conditions that they're seeing may not be something that they have encountered on a regular basis, it is at least something they've been exposed to in their training."

However, Dr. Shumaker raised a concern about the availability of advanced scar repair treatments outside large military centers. "During the initial intensive rehabilitation process at the military treatment facility, we may see them on a semi-residential basis for approximately six to 18 months," he said. "But people often have families elsewhere, and they will be transitioning to other parts of the country where these techniques may not yet have diffused widely into the civilian realm." Therefore, he explained, dermatologists in other practice settings may not be familiar with some of the treatments their patients have received. "But I think as time goes on and these treatments are applied more commonly in civilian environments, this will be less of an issue," Dr. Shumaker said.

In his experience, Dr. Kobayashi believes most veterans with traumatic injuries will continue their care within the military medical system. "The reason is there's a lot more experience that we have with treatment of the burn and traumatic scars and we have a lot of resources available here at our military treatment facility," he said.

**IMPACT ON CIVILIAN DERMATOLOGY**

Civilian dermatologists and their patients continue to benefit from military advances. "The pioneering of the laser treatment of traumatic and burn scars started in the military, and this research is definitely being carried on in the civilian world," Dr. Kobayashi said.

Maj. Gen. Bart Iddins, MD, commander of the 59th Medical Wing, explained that his wing's commitment to exceptional health care for U.S. service members has led to significant innovations that will extend beyond military medicine. "Our obligation to the brave men and women who defend America has led to new research and innovative procedures, not only in dermatology, but across the entire spectrum of military medicine. Ultimately, these advancements will lead to improvements in the health care of all Americans."

**CONCLUSION**

It has been said that medicine is the only victor in war, Dr. Shumaker said. "In my world these advances in rehabilitation are some of the examples — where we can improve range of motion; we can improve fit and comfort of prosthetic devices; we can accelerate rehabilitation. Because a lot of these procedures are relatively noninvasive, well-tolerated, and can be performed in the outpatient setting, we can intervene earlier in the patients' course, get them on track faster, get them back to work, and get them back to their real life faster than they could otherwise," Dr. Shumaker said.

However, he said, dermatology tools complement other therapies; they do not replace them. "I just want to emphasize that although there are some exciting breakthroughs going on in dermatology that are going to be life-changing, it is best to think of them as adjuncts to existing treatments such as physical therapy and surgical revision," Dr. Shumaker said.

As specialty leader for dermatology, serving as the consultant to the Navy Surgeon General, Dr. Belin disseminates information from the medical policy makers to members of his community and brings community concerns back to medical leadership to help effect policy change. "These are interesting times that we live in, but as military dermatologists we have the flexibility and training to meet those challenges, regardless of their nature," Dr. Belin said. dw
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We are the authorized distributor for the AAD’s Member Buying Program. This program brings you supply chain savings and solutions for your practice.
As dermatologists, we have a full plate of issues floating in the air that — when settled — could drastically affect our patients and practices. From indoor tanning regulations to squeezed provider networks, our specialty is facing life-changing policies from all corners of the health care arena. As you have just read in this month’s cover story, the future of many of our priorities will be affected by the election outcomes in November. As engaged citizens, we know it is our duty to vote for the candidate who will best serve our patients and practices. With the 2014 American Academy of Dermatology Association (AADA) Legislative Conference still fresh in my mind, I would argue, however, that there is so much more we should be doing to participate at all policy levels.

This year at the Legislative Conference — held Sept. 7-9 in Washington, D.C. — I joined about 140 of my colleagues for two days of policy and advocacy boot camp. We dug into the unsettled issues facing our specialty and patients. We drilled into our country’s changing payment models and how the use of data and payment transparency will affect the delivery of dermatologic care. We also discussed advocacy at the state level and how to use coalitions to advance our issues, such as indoor tanning, medical research funding, and skin cancer prevention.

One of the most pressing issues that we addressed is the lack of patient access that has stemmed from increasingly narrowed provider networks. As a result of the Affordable Care Act, Medicare Advantage payments were cut from 114 percent of Medicare to 104 percent. Consequently, in 2013 Humana and United Healthcare (UHC) Medicare Advantage (MA) plans started narrowing the scope of the provider networks they offer. Many dermatologists were notified — either directly by the health insurer or indirectly by their patients — that they were being terminated. Additionally, the AADA found that the UHC MA physician network terminations failed to provide a meaningful appeals opportunity, disclose the criteria used to determine the provider’s network status, or give sufficient notification to providers and patients.

Recently, the AADA evaluated five UHC MA networks to determine network adequacy and found that — based on Medicare’s own definition of network adequacy — UHC MA’s networks have an inadequate number of dermatology specialists and subspecialists. Additionally, the network rosters are inaccurate or misleading — listing physicians who are no longer accepting patients and even some who are deceased — and wait times for important dermatologic procedures are through the roof. This disturbing trend is putting our patients’ care in jeopardy, especially those most in need of care.

As a unified group, we took these cold, hard, facts and went to the Hill. All told, our specialty met with more than 180 congressional offices. When I think of a 2011 Congressional Management Foundation survey that found that 97 percent of congressional staffers believe that in-person visits from constituents have an influence on members of Congress, I am confident that our army of 140 made an impact.

However, we cannot stop at one day on the Hill. I call on every dermatologist to get involved beyond placing a ballot in a box. Attend the 2015 AADA Legislative Conference. Visit with your state and local representatives. Learn more about how SkinPAC, the AADA’s political action committee, makes a difference on Capitol Hill at www.skinpac.org. Also, write to your federal members of Congress through the Academy’s Dermatology Advocacy Network at www.aad-dan.com. I also encourage everyone to call on their patients who no longer have access to care because of these narrowed networks, and tell them to contact CMS. For more information on narrowed networks, contact David Brewster at dbrewster@aad.org. As physicians, we are not just concerned constituents; we are experts in public health. We are not just representing ourselves; we are speaking on behalf of our patients. Engaging in advocacy at the individual level will make a dent in the formation, or lack thereof, of the policies that affect our patients and practices. dw
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Board approves dues increase for spring ballot

The Board of Directors of the American Academy of Dermatology approved putting a dues increase on the spring 2015 ballot. If approved, a $50 increase would take effect in 2016; in future years dues would rise based on a cost-of-living adjustment (specifically the Consumer Price Index, or CPI-U) unless the Board voted not to increase them. The initial increase is intended to support the creation of proprietary data collection and analysis tools for dermatology, while subsequent cost-of-living-based updates are designed to ensure that the organization’s ability to serve members is not undermined by inflation. Academy Secretary Treasurer Suzanne M. Olbricht, MD, will outline the need for this increase in her report in next month’s *Dermatology World*.

The AADA Board approved two position statements, “Opposing Financial-Based Credentialing Including Narrowing of Provider Networks of Physicians” and an updated position statement on teledermatology. The full text of both is available at www.aad.org/Forms/Policies/ps.aspx.

The Board also adopted changes related to the nomination and election process. The online town hall will now allow AAD members to submit up to two questions to candidates during the election period. A new governance policy clarified the criteria to be used in identifying candidates and the restrictions on candidacy for members of committees that nominate candidates.

The Board expanded eligibility for the Program for Innovative Continuing Medical Education in Dermatology (PICMED), a move that should allow various educational and research projects/activities to qualify for grant funding. It also approved the creation of a new Maintenance of Certification activity related to psoriasis to help members complete part four of MOC; the activity will allow members to complete part four by conducting chart audits and attending a live session during the Academy’s Annual Meeting.

Finally, George Hruza, MD, was chosen to serve on the Board’s Executive Committee from the close of the 2015 Annual Meeting until 2017. – RICHARD NELSON

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Feedback sought for AAD Practice Profile and Workforce Survey

THE AMERICAN ACADEMY OF DERMATOLOGY (AAD) asks members to complete the 2014 Dermatology Practice Profile and Workforce Survey if invited. This survey aims to capture the reach and scope of dermatology practices, and will assess the composition and distribution of the dermatologic workforce in the U.S.

Specifically, the AAD seeks to identify:
- The number of and specific locations where individual physicians provide patient care
- Physicians/practices that treat patients for specific conditions
- Physicians/practices that perform specific procedures at each practice location
- The size of each location where an individual physician practices (number of physicians, non-physician clinicians, and other office staff)

The AAD encourages all invited physicians to participate and provide feedback. The online survey will be launched early October, and paper surveys will be mailed to non-responding members shortly thereafter. The survey will remain open through November. For more information on the 2014 Dermatology Practice Profile and Workforce Survey, contact the survey research department at surveyresearch@aad.org or 847-240-1767.

– VICTORIA HOUGHTON
Grants available for technology-based teaching applications
Applications due Feb. 2, 2015

THE SULZBERGER INSTITUTE for Dermatologic Education Committee is interested in receiving proposals for technology-based teaching applications to further clinical education in dermatology and dermatologic surgery. Proposals from individuals with a clear association to dermatologic organizations will be given preference; however, all proposals to develop technology for dermatology education will be considered. The deadline for submission of requests is Feb. 2, 2015. Successful applicants will be notified of their award by June 2015 with funding to begin in 2015.

Grants are available in three categories:
- Seed grants (up to $60,000 per year) for a period of one to two years.
- Small grants (up to $5,000) for a period of one year.
- Tuition support (up to $7,500) for education and accredited technology courses.

The Sulzberger Institute Committee has established the following criteria for evaluation of the proposals:
- Perceived value of the project to dermatologic education;
- Practical and innovative use of audiovisual and technology methods within the scope of the proposal;
- Clarity and completeness of the project abstract; and
- Willingness to grant the American Academy of Dermatology the right of first refusal to partner with the grant recipient in the development and marketing of any potential products which may result from the research effort. (This criterion does not apply to applications for the travel award.)

For more information, contact Meredith Rund, education specialist, at mrund@aad.org or visit www.aad.org/education/awards-grants-and-scholarships/sulzberger-institute-grant.

– MEREDITH RUND

American Board of Dermatology announces 2015 exam dates

THE AMERICAN BOARD OF DERMATOLOGY has announced dates and locations for the 2015 in-training, certification, and recertification exams. For more information visit the ABD website at www.abderm.org.

– VICTORIA HOUGHTON

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DATEBOOK
WHAT’S COMING UP

NOV 1
2015 election nominations due. See www.aad.org/aadnominations.

MARCH 20-24, 2015
73rd Annual Meeting in San Francisco. See www.aad.org/meetings.

JUNE 8-13, 2015
World Congress of Dermatology in Vancouver.

AUG 19-23, 2015
Summer Academy Meeting 2015 in New York.

OCT 1, 2015
ICD-10 compliance deadline. See www.aad.org/icd10.
Nominations sought for 2015 AAD election

THE AMERICAN ACADEMY OF DERMATOLOGY Nominating Committee seeks nominees for the offices of president-elect, vice president-elect, Board of Directors, and Nominating Committee member representatives (NCMR) in the Eastern Region. The current Administrative Regulation on Nominations and Election Procedure requires that nominees submit all the required materials to the Nominating Committee no later than Nov. 1, 2014, for the election that will take place in spring 2015.

Successful officer and director candidates will take office in March 2016 at the close of the 74th Annual Meeting in Washington, D.C., and the successful NCMR will take office immediately. Nominees for the offices of president-elect and vice president-elect must have served on the Academy Board of Directors for at least one year prior to assuming office. President-elect-nominees incur a four-year commitment — a one-year commitment prior to serving as president-elect, one as president-elect, one as president, and one as immediate past president. Vice president-elect-nominees assume a three-year commitment — a one-year commitment prior to serving as vice president-elect, one as vice president-elect, and one as vice president and one as vice president.

The Nominating Committee screens and evaluates all nominees and selects a definitive slate of candidates based on professional, scholarly, and administrative skills as well as geographic representation. Remember, make your nomination(s) early to ensure that nominees have the necessary time to complete and submit all the required materials no later than Nov. 1.

The 2015 Nominating Committee Fellows of the American Academy of Dermatology are C. William Hanke, MD, MPH, chair, Scott D. Bennion, MD, Amy J. Michael, MD, Ronald L. Moy, MD, Stephen M. Purcell, DO, and Darrell S. Rigal, MD. Submit nominations to www.aad.org/aadnominations or by mail at:

American Academy of Dermatology Attn: Call for Nominations 930 E. Woodfield Road Schaumburg, IL 60173-4729

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

— JOAN TENUT

Academy seeks assistant secretary-treasurer nominees

APPLICATIONS AND NOMINATIONS are now being solicited for the position of assistant secretary-treasurer for the American Academy of Dermatology and AAD Association. The term begins March 2016. Barbara M. Mathes, MD, is the current assistant secretary-treasurer.

Members interested in serving the Academy in this position should have significant administrative and financial management experience. The position of assistant secretary-treasurer requires a considerable time commitment. Applicants must be able to serve for six years: three years as assistant secretary-treasurer and three additional years as secretary-treasurer.

Pursuant to administrative regulation, Academy President Brett M. Coldiron, MD, appointed the 2014 Assistant Secretary-Treasurer Search Committee. Vice President Elise A. Olsen, MD, chairs the committee. The other members of the committee are Secretary-Treasurer Suzanne M. Olbricht, MD, Assistant Secretary-Treasurer Dr. Mathes and Board members George J. Hurza, MD, Kathy Schwarzenberger, MD, and Kevin D. Cooper, MD. Dr. Coldiron and Elaine Weiss, JD, executive director and CEO, will serve as ex-officio committee members. The committee will interview applicants and recommend finalists to the Board of Directors who will conduct interviews and make the final decision.

The nomination form, application, and position description are available on the AAD website at www.aad.org/AST.

Applicants for the position must be available to attend the 2015 Annual Meeting in San Francisco. Final interviews will take place at the May 2015 AAD Board of Directors meeting in Chicago.

All materials should be submitted electronically whenever possible, including an abbreviated curriculum vitae. All inquiries are confidential. Nominations with completed applications must be received by Jan. 9, 2015.

Questions may be directed to Cyndi Del Boccio in the AAD Executive Office at (847) 240-1041 or cdelboccio@aad.org.
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#### Charleston, South Carolina
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The collage below shows the good time had by all involved, from the campers who had an experience to remember to the volunteers who made that experience possible.

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