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We lost a great man recently.

Funny, because I am sure he would strongly object to being called this. It takes only a glance at his CV to appreciate that Stephen I. Katz, MD, PhD, was an extraordinary physician, scientist, and leader in our field. His work in immunodermatology framed our present understanding of many immunobullous diseases and, indeed, helped us understand many of the basic immunologic mechanisms in the skin. What his CV fails to convey is what an extraordinary, yet very ordinary, person Steve really was.

During his tenure as head of the National Cancer Institute Dermatology Branch, Steve trained innumerable physician fellows from all over the world, many of whom are now successful, independent researchers and leaders. Steve considered this to be his greatest professional success. Those of us who trained in his branch knew him to be a very dedicated, fair, and humble teacher. He shared his knowledge freely and took great delight in the success and personal growth of others. He had a unique ability to “give it all away.” I was never enough of a scientist to challenge his knowledge in the lab, but I did have the opportunity to stump him with a clinical diagnosis in a patient who presented with a rather unusual variant of a common disease. I still recall his delighted laughter when I revealed the answer. Steve made it okay not to know everything, and as brilliant as he was, would always claim that others were smarter than he — in particular, his older brother and hero, Robert.

Steve connected with people in a way that few of us are able. It was said at his funeral that the synagogue was filled with many people, each of whom believed they were Steve’s best friend. He remembered names and seemingly insignificant details of people’s lives, and he went out of his way to make everyone feel important. He followed the careers of his former fellows long after they left the Branch, and never missed an opportunity to contact us with words of congratulations or encouragement. I still have the gift he and his wife, Linda, graciously sent at the birth of my child almost 18 years ago. Steve responded to emails and answered his own phone. He played softball during the annual Navy vs. NIH Dermatology Branch grudge match and delighted us with his guitar playing whenever the opportunity arose. He loved his family dearly and was incredibly proud of his children.

I’m pretty sure if Steve were still with us, he would remind us to work hard, but to spend time with our families and friends, to be kind to everyone and, in my case, to publish more. He will be sorely missed, but his legacy will live on in his family, as well through those of us lucky enough to have known him as teacher, mentor, and friend.

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR
ONLINE at aad.org/DW

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Next month’s question

Next month, Dermatology World’s Water Cooler column wants to know...

How much paid vacation do you give your staff?

Send your response to watercooler@aad.org.

Q How do you get your CME credits?

“The AAD’s Question of the Week is one sure way.”

— Hassan Galadari, MD, Dubai, United Arab Emirates

“Grand rounds, AAD meetings, and Question of the Week.”

— Caroline Halverstam, MD, New York

“I attend local derm group meetings and journal clubs. Also, JAAD CME articles, and annual conferences.”

— Tiffany Clay, MD, Atlanta

“Live CME meetings.”

— Joshua Zeichner, MD, New York

“Dialogues in Dermatology. Love listening to the podcast on the Dialogues in Dermatology free smartphone app — so convenient!”

— Shadi Kourosh, MD, Boston
What is the minimum I need to report to meet the MIPS threshold in 2019?

If you or your practice must participate in the Merit-based Incentive Payment System (MIPS) for 2019 and want to simply avoid the 7% penalty (penalty applied in 2021), the minimum score to avoid the penalty is 30 points — up from 15 points in 2018. The minimum score to achieve the maximum incentive of 7% is 75 points — up from 70 points in 2018.

**PERFORMANCE CATEGORIES**
The performance categories remain the same in 2019: Quality, Improvement Activities, Promoting Interoperability, and Cost. However, the weights for 2 out of 4 categories have changed:

- Quality reduced to 45% from 50% in 2018
- Cost increased to 15% from 10% in 2018

Improvement Activities and Promoting Interoperability remain at 15% and 25% respectively.

Small practices with 15 or fewer providers can meet the 30-point threshold and avoid the penalty by reporting:

**Without an EHR:**
- 5 quality measures one time each (between Jan 1. – Dec 31., 2019) PLUS 6 bonus points automatically added to numerator for small practices PLUS
- 1 high-weighted Improvement Activity (for 90 consecutive days; last day to begin participation Oct 2., 2019)

(TOTAL POINTS: 30.75)

**With an EHR:**
- 1 high-weighted Improvement Activity for all eligible patients for 90 days (last day to begin participation Oct 2, 2019) PLUS
- 3 Promoting Interoperability measures

(TOTAL POINTS: 32.5)

To learn more about what's new with MIPS in 2019, flip to page 24. dw

Looking for more answers?
Send your burning questions to Dermatology World’s Asked & Answered column at dweditor@aad.org, and keep an eye out for the answer in an upcoming issue of Dermatology World!
What’s hot?

In this monthly column, members of the Dermatology World Editorial Advisory Workgroup identify exciting news from across the specialty.

Deepak Gupta, MD

The landscape for genetic discovery and therapeutic targets in vascular anomalies has significantly changed over the years. Arteriovenous malformations (AVM) have benefitted from gene discovery. All AVMs progress throughout life causing significant morbidity and even mortality due to pain, bleeding, deformity, and at times, cardiac dysfunction. They are difficult to treat, with limited therapeutic options and high rates of reoccurrence. Work published earlier this year discovered multiple mosaic-activating mutations in the RAS/MAPK pathway, which is a pathway commonly found activated in certain cancers. Specifically, mutations were found in KRAS, BRAF, and most commonly in MAP2K1 (J Clin Invest. 2018; 128(4): 1496–1508). MAP2K1 encodes mitogen-activating protein kinase 1 (MEK1), and endothelial cells carrying this mutation form abnormal vascular channels and networks between arteries and veins. A recent case report uses trametinib, a MEK inhibitor, for the treatment of AVM (JAMA Dermatology. doi:10.1001/jamadermatol.2018.4653). After one year of treatment there was improvement in symptoms and significant decrease in volume of the AVM. BRAF inhibitors, such as vemurafenib, have also been implicated in treatment of AVMs. There are still many questions left unanswered regarding use of MEK and BRAF inhibitors in AVM, such as duration of therapy and long-term sequelae. Use of these inhibitors may offer a promising targeted therapy, albeit not a cure, for a disease with limited therapeutic options and high morbidity.

Edward W. Cowen, MD, MHSc

Many of us struggle with patients with refractory pruritus who have tried many combinations of antihistamine, tricyclic, and immunomodulatory agents and continue to scratch. Finally, progress is now being made in better understanding the pathways involved in the itch-scratch cycle.

Brian Kim, MD, co-director of the Center for the Study of Itch at Washington University, is focused on the innate immune mechanisms that underlie skin inflammation and the sensation of itch. His group has identified certain key cytokines in atopic dermatitis (IL-4 and IL-13) that also function directly as key master regulators of the sensation of chronic itch. Kim’s group showed that the TH2 cytokines IL-4 and -13 directly activate sensory neurons through a shared IL-4 receptor subunit, which is also shared by Janus kinase (JAK) 1 (Cell. 2017; 171: 217-28.e13). IL-31 is another TH2 mediated cytokine which has been implicated in atopic dermatitis and other pruritic conditions such as prurigo nodularis and CTCL (J Allergy Clin Immunol. 2018; 142: 1375-90).

Dissecting the mediators of itch (also known as pruritogens) could have immediate impact on our patients. They are already benefiting our pets. Oclacitinib, a JAK 1/3 inhibitor, was approved in 2013 to treat dog scratching/atopic dermatitis. Cytopoint® is a caninized monoclonal antibody which neutralizes IL-31 and was approved in 2016 for canine atopic dermatitis. It remains to be seen if dupilumab—which blocks IL-4 and -13 and is approved for adults with moderate/severe atopic dermatitis—or related drugs in the pipeline, will lead to similar benefit in humans with chronic pruritus without atopic disease.
Close observation with routine skin surveillance is a reasonable approach to moderately dysplastic nevi according to a recent study in *JAMA Dermatol.* (2018;154(12):1401-1408). In a study of 467 moderately dysplastic nevi with positive histologic margins, no lesion developed into cutaneous melanoma. The mean follow-up time was 6.9 years. There are some limitations including that patients were only reviewed if they had more than three years of follow-up, so if anyone developed a melanoma within three years that would not have been detected. Incidentally, the authors noted that patients with two or more biopsied moderately dysplastic nevi had an increased risk for melanoma at a separate site. While a larger study is preferable and no recommendation for follow-up intervals can be gleaned from this study, it does add to the literature that it may be appropriate to monitor patients with moderately dysplastic nevi with positive margins on biopsy.

Rosacea is thought to be associated with factors involved in metabolic syndrome (MetS). Relative muscle mass is negatively associated with increased rosacea severity, suggesting that skeletal muscle could be protective against rosacea exacerbation.

Researchers in a cross-sectional study investigated the link between rosacea severity and relative muscle mass. Study participants were patients at a hospital screening center in Korea and had regular skin checkups for two years. Dermatologists took polarized light photographs of participants’ faces and evaluated them. Similarly, participants’ skeletal muscle index (SMI) was estimated with a bioelectrical impedance analyzer (% = total skeletal muscle mass in kg/body weight in kg x 100). The associations between SMI and rosacea severity were evaluated using a logistic regression model.

84.5% of 110 participants had erythematotelangiectatic rosacea and 15.5% with papulopustular rosacea. Mild rosacea was seen in 75.5% of participants, moderate rosacea in 24.5% and severe rosacea in 0 participants. A significant decreasing trend was seen in rosacea severity with increasing SMI.

This association was not observed for mild rosacea. After the findings were analyzed according to sex, this association was observed in women, but was inconspicuous in men. The conclusion of the study is that it is likely that skeletal muscle is a protective factor for severe rosacea ([J Dermatol. doi: 10.1111/1346-8138.14689]).
A recent article in *Dermatitis* — reporting on the North American Contact Dermatitis Group’s (NACDG) most recent patch test results — highlights the importance of patch testing as the standard criterion diagnostic tool for evaluating patients with suspected allergic contact dermatitis, as well as the benefit of expanded testing trays. Every few years this group reports on their patch test findings, a collective data set from 13 centers in North America. They highlight new allergens, most common allergens and allergens with the highest relevance, as well as how likely smaller screening series would be able to fully detect and manage patients. In this reporting cycle, nickel remains the most commonly detected allergen. The European Union has implemented regulations that limit the level of nickel available to consumers through skin contact. Limitations in nickel exposure in the United States would help to decrease allergy and allergic reactions to this allergen and the American Contact Dermatitis Society is making efforts to encourage similar limitations. Methylisothiazolinone, recently added to the screening series in 2013, was the second most positive reaction. Methylisothiazolinone was previously tested as a mix with methylchloroisothiazolinone and it is now also tested alone. The rate of positivity has increased from the last study and it also has the highest significance-prevalence index number (SPIN) — highlighting the importance of this allergen which would not be detected with standard 36 testing series. Fragrance mix was the third most common allergen reported and had the second highest SPIN. In addition to highlighting many other allergen trends, the authors estimated that standard allergen trays of 36 would hypothetically miss 25-40% of reactions detected by their larger NACDG series. Additionally, 23% of patients (many occupationally related cases) required more extensive testing than even the expanded NACDG series in order to detect causative allergens. This study reinforces the benefits gained in the management of allergic contact dermatitis when adequate history, physical examination, and extended patch testing is conducted (*Dermatitis*. 29(6):297-309). dw

**Will your patient’s undifferentiated pleomorphic sarcoma behave indolently or aggressively?**

A recently published multicenter, retrospective chart and histopathologic review of 319 patients with skin and soft tissue spindle cell neoplasms that are currently classified as undifferentiated pleomorphic sarcoma (UPS), was conducted to identify clinical and histopathologic features that predict aggressive behavior. The authors of this large review found that invasion of the tumor deep into the subcutaneous fat and tumor size larger than 2 cm in diameter significantly predicted a more aggressive tumor. Older age at diagnosis, tumor invasion into lymphovascular space, and a history of immunosuppression were also associated with significantly increased risk of mortality.

Because of the prognostic impact of tumor depth, the authors propose that UPS be subcategorized into superficial UPS and deep UPS. This study reminds us of the importance of adequate deep sampling and histopathologic evaluation of the tumor, and may help guide clinicians in recommending adjuvant treatment and frequency of surveillance (*J Am Acad Dermatol*. 2018;853-9).

**Are you a rash whisperer?**

Read more about allergic contact dermatitis at [www.aad.org/dw/monthly/2019/january/are-you-a-rash-whisperer](http://www.aad.org/dw/monthly/2019/january/are-you-a-rash-whisperer).

Christen Mowad, MD

Christopher Messana, DO, JD
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Freedom to realize the benefits of your hard work
Biopsy coding: Pathology particulars

By Alexander Miller, MD

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

Now that the biopsy codes are stratified by biopsy technique — tangential, punch, and incisional — how should such techniques be transmitted to the pathologist/dermatopathologist ultimately reading the biopsy slides? Do different techniques make a difference for the physician reading the slides? Well, yes. Let’s examine why.

Tangential biopsy specimens (CPT codes 11102, 11103) will consist of epidermis with or without underlying dermis. They are not full thickness, through the dermis. Consequently, both the physician doing the biopsy and the pathologist reading the slides should consider why this technique was selected. They should expect to see epidermis and/or dermis on a biopsy slide. Although the CPT definition of a tangential biopsy states that epidermis and/or dermis would be identified on a tangential biopsy, there are instances in which the epidermis is removed in a given lesion. In such situations, a tangential biopsy would reveal an absence of epidermis, or only remnants of epidermis along with dermis. These specimens would still be considered tangential biopsies.

Punch biopsies (CPT codes 11104, 11105) must be obtained with a punch tool, and must be full thickness specimens, with the punch depth penetrating into the subcutaneous space or tissue. Thus, one may see subcutaneous fat or muscle attached to the deep aspect of a punch biopsy, but not always. There are instances in which the subcutaneous tissue has either detached from the deep dermis or there is little to no subcutaneous tissue to be found deep to the dermis — such as on the ventral ear pinna overlying cartilage.

Incisional biopsies (CPT codes 11106, 11107) may be submitted in any shape, but commonly would be fusiform in configuration. Similar to punch biopsies, the specimen should be full-thickness skin, penetrating into the subcutaneous space. Depending on the lesion being biopsied, an incisional biopsy may contain copious attached subcutaneous fat. However, seeing fat on the biopsy tissue is not required because penetration into a subdermal space does not stipulate attachment of fat or other subcutaneous tissue.

All biopsy modalities are used for sampling a lesion for diagnostic histopathology evaluation. If the intent is to remove the lesion and any dermis remains at the base of the wound, the procedure should be reported as a shave removal rather than a tangential biopsy. If the intent is to remove the entire lesion with margins through the entire thickness of the dermis, then a benign or malignant excision code (CPT codes 11400-11646) would be appropriate, regardless of the technique used.

Ideally, the physician reading a biopsy specimen should benefit from essential information that would help to generate optimal histopathology readings. Clinicopathological correlation aids in directing attention to tissue adequacy/inadequacy for reaching a given suspected diagnosis and helps the slide reader to focus upon characteristics that may support or refute a given differential diagnosis, or to realize that a specimen is adequate/inadequate for optimal evaluation. Pathology requests that include only patient identifiers and a location of the biopsy are inadequate. Requests that state: “Rule out cancer” supply very limited information. One would wonder: What kind of cancer and at what depth within the biopsy would such a
cancer be expected? For example, if one suspects a deep malignancy, such as a dermatofibrosarcoma protuberans, and the biopsy is superficial, the pathologist may end up focusing upon the common epidermal-dermal malignancies and fail to comment upon a potential inadequacy of the specimen for diagnosis.

Similarly, if a pathology requisition states, “dermatitis,” and nothing more, one would have no way of determining whether the submitted tissue was adequate. A superficial tangential biopsy may be adequate for the diagnosis of contact allergic dermatitis but inadequate for the diagnosis of a deep granuloma annulare or an infectious granulomatous process. It helps, of course, to generate a clinically relevant differential diagnosis from the get-go and transmit it to the dermatopathologist. Sometimes the transmission is not done, and sometimes there is nothing to transmit because the individual doing the biopsy is unsure of what they are biopsying. Assuming that a dermatopathologist would magically extract a diagnosis from a submission lacking helpful information and/or from inadequately biopsied tissue may not be realistic.

What helpful information may be supplied on a pathology requisition? Below are suggestions:

1. Specimen location
2. Biopsy technique: tangential, punch, or incisional
3. Clinical description may include:
   a. Lesion description (including size, possible depth)
   b. Dermatitis description
   c. Extent of lesion, such as a dermatitis (diffuse vs. localized)
4. Prior treatment, such as with topical or systemic steroids, or surgical, chemical, or radiation treatment
5. Clinical diagnosis/differential diagnosis
6. Any other information one would like to receive from the dermatopathologist

What if you read your own slides? One certainly should not have to regurgitate charted information to oneself, as such details can be readily extracted from a chart reading.

**Example 1**

You use a blade to tangentially remove a dome-shaped, clinically benign nevus from the cheek of a patient who hates the mole and wants it removed. You report your service to the patient’s Medicare Administrative Contractor (MAC) as a tangential biopsy, CPT code 11102. The histopathology reveals a benign intradermal nevus, and the service is billed to the MAC with CPT code 88305.

**Answer: Incorrect.** The intent of the procedure was not diagnostic, and the procedure was cosmetic and not medically necessary. Therefore it should not be billed to a payer.

Removal of benign lesions that do not pose a threat to structure and function but, rather, constitute appearance annoyances, is not a covered Medicare service. The patient would have to be apprised of statutory non-coverage prior to the procedure. In such instances, the full expense is the patient’s responsibility. An Advanced Beneficiary
Notice of Noncoverage (ABN), available from the MAC or CMS website (www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html), would have to be signed by the patient prior to the service if Medicare billing were requested by the patient. Similarly, the patient should also sign a financial responsibility consent for claims submitted to private payers informing them of their financial responsibility, should the claim be denied by insurance as a non-covered service.

Example 2

You have an outside laboratory process tissue specimens and send you the slides for histopathology interpretation. The laboratory bills Medicare for slide preparation, and you bill Medicare for the professional component with CPT code 88304.26 or CPT code 88305.26. You list the date of service as the date that you read a slide and generate a report.

Answer: Correct. In general, Medicare directs that laboratory services be billed with the date of service as the date of specimen acquisition. However, histopathology is interpreted differently. The technical component (TC) should be billed with the date that the specimen was acquired. For some payers, the slide interpretation and report — professional component (.26) — is billed with the date of the reading and report. If one has an in-house processing lab, the global CPT code 88304 or 88305 would only be billed if the interpretation/report was done on the day the specimen was acquired. If the specimen is acquired on a date different from that of the slide reading/report, check directly with the payer for specific guidance. For example, some private insurers require that both the technical and professional services be billed with the specimen acquisition date of service.

A note of gratitude to the Healthcare Finance Committee and Dermatopathology Rapid Response Committee for their contribution to the development of this article.

Cracking the Code clarification

In the December Cracking the Code column, Biopsy Coding in 2019: Part 2, the fifth example requires clarification. The example has been clarified online and is as follows, with updates in bold:

Example 5

During a complete skin examination of a patient with dysplastic nevi you identify a 1.2cm-wide pigmented patch suspicious for a melanoma. You proceed to do a diagnostic full-thickness, into subcutaneous fat removal of the lesion with 3 mm clinical margins. You select CPT 11602, excision, trunk, 1.1-2.0 cm diameter, as the histopathology confirmed a melanoma.

Answer: Correct/True. Your intent was to diagnose the lesion with a full thickness excision (removal) with margins. This meets the definition of an excision incisional biopsy. An incisional biopsy is a sampling of a lesion, which implies a partial removal and/or an absence of intent to remove a lesion full-thickness, with margins. The corollary of this is that an incisional biopsy code, 11106, is inappropriate. This procedure should neither be reported or adjudicated as an excision be reported or adjudicated as an incisional biopsy.
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The American Academy of Dermatology Association (AADA) maintains a robust state policy advocacy program that provides a voice to dermatologists at the state level to ensure that public policies and regulations address the ever-changing needs of practices and patient care. The AADA’s state advocacy program is led by members of the State Policy Committee (SPC), who offer member expertise and leadership on state issues pertinent to dermatology and provide input to staff when developing positions and strategy.

Coalitions and partnerships
The AADA works with multiple coalitions centered around legislative priorities to harness the power of different stakeholders to maximize influence and effectiveness. These coalitions include:

- **State Access to Innovative Medicines Coalition**: Advocates for legislation that improves and increases the transparency of step-therapy protocols.

Advocacy at the state level is so important as the practice of medicine is regulated and often legislated here. The AADA State Policy Committee (SPC) is dedicated to helping our dermatologist communities and our patients. Issues such as scope of practice, preventing and enforcing minors from using tanning beds, allowing safe, in-office compounding, and easy access to affordable medications are some of the key issues SPC will be fighting for this year. If these issues come up in your state, we want to be there to help advocate — whether it’s to pass legislation or prevent it. If these issues are not coming up in your state, we want to help you put them on your state’s agenda. Additionally, if there is something else important regarding your practice and patient care in your state, the SPC is there to help. I hope more of our membership gets involved in advocacy at the state level. It’s local and personal here, and together we can make such a difference!

— Larry Green, MD, chair, AADA SPC

The AADA participates in several state-based step therapy coalitions as well in Georgia, Ohio, Maine, Massachusetts, Washington, and Wisconsin.

- **Biologics Coalition**: Shares information and discusses questions around substitution and interchangeability, labeling, pharmacovigilance, and tracking, as well as formularies and payment.

- **Scope of Practice Partnership**: Collaborative effort of the American Medical Association, American Osteopathic Association, national medical societies, state medical associations, and state osteopathic medical associations that focuses the resources of organized medicine to oppose scope of practice expansions by non-physician providers that threaten the health and safety of patients.

- **Drug Quality and Security Act Coalition**: A state- and federal-level coalition working to preserve patient access to vital compounded medications.
Patient Protections Working Group: Provides a platform for patient-centric organizations and medical groups/professionals to collectively capture existing resources relating to step therapy, nonmedical switching, and any future patient-access issue the working group wishes to address.

Alliance for Transparent and Affordable Prescriptions: A partnership of patient and provider organizations dedicated to education and advocacy at the state and federal levels addressing pharmacy benefit managers and their impact on prescription drug costs and patient access to affordable treatment.

2019 meetings and activities
In 2019, the AADA SPC will attend or host the following activities and events:
- American Medical Association’s State Legislative Strategy Summit, “Successful Advocacy in Turbulent Times” (Scottsdale, Arizona, January)
- State Policy Committee Meeting – Academy Annual Meeting (Washington, D.C., March)
- National Conference of State Legislatures skin cancer screening (Nashville, Tennessee, August)
- American Medical Association’s State Legislative Roundtable (Napa, California, August)

State Advocacy Grant Program
The AADA’s State Advocacy Grant Program provides financial assistance to state dermatology societies for the advancement of their health policy initiatives, including state lobbying expenses. For 2019, the AADA’s SPC awarded grants to nine state dermatology societies, including Arizona, California, Florida, Maryland, Minnesota, Missouri, Ohio, Pennsylvania, and Rhode Island. Learn more about the Academy’s State Advocacy Grant Program at www.aad.org/advocacy/state-policy.

Is your state dermatology society having an advocacy day?

We’d love to help! Contact Lisa Albany at lalbany@aad.org, or Victoria Pasko at vpasko@aad.org for more information.
What can dermatology expect from the federal government and the AADA in 2019?

FEDERAL NEWS ROUNDUP

BY VICTORIA HOUGHTON, MANAGING EDITOR

In this new column, Dermatology World breaks down the latest highlights of AADA advocacy activities at the federal legislative and regulatory level.

It’s 2019 and this year, the new 116th Congress and the Trump Administration will face a full docket of issues affecting the specialty, such as:

- In-office compounding
- Patient access to care
- Skin cancer research funding
- Telemedicine
- Drug pricing and availability
- Medicare physician payment

The American Academy of Dermatology Association (AADA) — the advocacy arm of the Academy — provides a voice to dermatologists, ensuring that public policies address the ever-changing needs of practices and patient care. The AADA will monitor and advocate on these issues, and will provide members with valuable resources and tools when needed.

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

Want to become an advocacy insider?
Want weekly updates on what the AADA is doing to advocate for you? Subscribe to the ‘Advocacy’ section of the Academy’s DW Academy Insider e-newsletter. Visit www.aad.org/account/communication and select ‘Advocacy’ under Dermatology World Academy Insider.

Want to get involved?
Getting involved in advocacy is easier than you think! Check out the AADA’s Advocacy Action Center to learn how you can get involved from the comfort of your home at https://takeaction.aad.org.

To learn more about AADA advocacy, visit www.aad.org/advocacy dw

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Is pigmented spindle cell nevus of Reed the result of genomic fusions?

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Pedram Gerami, MD, about his recent American Journal of Surgical Pathology article, “Genomic fusions in pigmented spindle cell nevus of Reed.”

Q. Dr. Schwarzenberger: You and your colleagues recently published your findings on the genomic fusions in pigmented spindle cell nevus (PSCN) of Reed. Can you briefly summarize your findings for those who may have not yet read your article?

Dr. Gerami: Pigmented spindle cell nevus of Reed is considered a morphologic variant of Spitz nevus — characterized by heavily pigmented spindle-shaped melanocytes. It can often be confused with, or misdiagnosed as, melanoma from both a clinical and histologic perspective. Recently it has been recognized that a significant proportion of Spitz nevi are the result of genomic fusions resulting in activation of certain oncogenes. These genes may be rearranged to a number of partners, but these fusions in melanocytic neoplasms result in constitutive activation of the kinase and increase cellular proliferation, leading to development of a Spitzoid neoplasm. Because of their similarities to Spitz, we hypothesized that PSCN of Reed might also be initiated by similar kinase fusions.

When we performed mRNA sequencing on 23 PSCN of Reed, we found more than half of our cases had a specific fusion involving the gene NTRK3. When we included other fusions previously described in Spitz, 78% of these PSCN of Reed had a fusion as an initiating genomic event. Each case only had one initiating event, and none had an initiating somatic mutation typically associated with melanocytic lesions like BRAF or NRAS. In terms of histology, the cases with NTRK3 fusions had classic features of Reed nevi but tended to have adnexal involvement and to occur in younger patients.

We also sequenced a number of other atypical melanocytic neoplasms, including acral and mucosal melanomas, pigmented epithelioid melanocytomas, Spitz nevi, atypical Spitz tumors, and Spitzoid melanomas. Of these atypical lesions, we only found NTRK3 fusions in 3% of Spitz nevi and none in the other types. Interestingly, these NTRK3 Spitz had exclusively spindle-shaped melanocytes and adnexal involvement — similar to our PSCN of Reed — but were different in that they had very little pigment.

Altogether, these findings suggested to us that NTRK3 fusions are the most common and characteristic initiating genomic event for PSCN of Reed. In contrast, NTRK3 fusions have rarely been found or reported in melanoma.

Q. Dr. Schwarzenberger: Can you help us understand the techniques that allowed you to make these findings?

Dr. Gerami: Our work has been enabled by next generation sequencing, which is the most comprehensive genomic assay and is becoming more popular. NGS can help us look at the whole genome, exome, transcriptome, or epigenome, or take a more targeted approach to understand the genomic changes in a tumor.

Compared to traditional Sanger sequencing, NGS can generate more genomic data with a smaller initial amount of DNA or RNA with a relatively short turnaround time. In simple terms, like in Sanger sequencing, a sequencer detects the addition of fluorescently-labeled nucleotides to template DNA strands. The advantage is that NGS analyzes millions of DNA fragments at the same time.
We used mRNA sequencing in this study to look for structural rearrangements, such as gene fusions. We looked at the whole transcriptome to find areas of mRNA transcripts that would code for a functional protein, but contain two genes that would not normally be located next to each other. Then, using fluorescence in situ hybridization, we used fluorescent probes to confirm that the genes we identified moved to a new location in the DNA of the tumor.

Fortunately, NGS is becoming cheaper and more precise, but much more work must be done to understand what changes in the genome are important in determining the classification and behavior of melanocytic tumors.

Q Dr. Schwarzenberger: Do these and other molecular abnormalities detected in spitzoid nevi have clinical significance, or are they used more as a way to classify these pigmented lesions?

Dr. Gerami: Because of recent advances in sequencing technology and our understanding of genomics, we are now able to incorporate this molecular data into the classification of melanocytic lesions in addition to clinical and histopathologic features. While most Spitz and Reed nevi can be diagnosed by microscopic methods alone, there are some cases with overlapping features with melanoma. Since NTRK3 fusions are rare in melanoma and contrastingly the most common melanoma mutations such as BRAF or NRAS mutations are rare in Spitz and Reed nevi, these differences can be leveraged to help diagnose difficult cases. While no single finding is definitive, the genomic initiating event can be included in the assessment when diagnosing morphologically challenging cases.

Q Dr. Schwarzenberger: Will these and other molecular studies help us distinguish between a PSCN of Reed and a melanoma?

Dr. Gerami: While no single data point can tell with 100% certainty if a melanocytic lesion is a PSCN of Reed or a melanoma, the identification of the initiating genomic event can be part of this assessment. The identification of an NTRK3 fusion highly favors a diagnosis of Reed nevus over melanoma. Although uncommon, it is possible for a NTRK3 fusion neoplasm to progress to melanoma. Alternatively, canonical BRAF and NRAS mutations — which are so typical of melanoma — are relatively rare in PSCN. Hence, this information can be included in the pathologist’s assessment.

Q Dr. Schwarzenberger: Next gen sequencing or fluorescent in situ hybridization (FISH): Should we order one or both, and, if so, when? Does the clinician need to request these studies, or will the pathologist know when to order them?

Dr. Gerami: Next generation sequencing is currently used for theragnostic purposes. By using identification-specific drivers, this can inform oncologists of potential therapeutic options in known cases of melanoma. Currently, next generation sequencing has a limited role in diagnosis and more studies are needed to show that the specific data points and mutations identified can play a role in diagnosing tumors. I believe this will happen over time. Currently, fluorescence in situ hybridization is a simpler targeted method with proven value as a diagnostic tool. dw
Family and Medical Leave Act of 1993

BY CLIFFORD WARREN LOBER, MD, JD

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

**Question:** My office manager is requesting that he be given a month’s leave after his wife gives birth to their first child next month. He asked that this be granted under the Family and Medical Leave Act (FMLA). He is really critical to our daily operations. What is the FMLA and must I grant his request?

**Answer:** The FMLA was enacted in 1993 to “allow eligible employees of a covered employer to take job-protected, unpaid leave, or to substitute appropriate paid leave for a total of 12 workweeks in any 12 months.” If you are a ‘covered employer’ and the employee qualifies for leave, you must grant it.

**Q:** The office manager is a man. Are men eligible to take leave to care for a newborn under the FMLA?

**A:** Absolutely! The Act applies to all employees regardless of their gender.

**Q:** What circumstances qualify for FMLA leave? I thought the FMLA only applied if the employee was seriously ill.

**A:** The Act requires that you grant leave (1) for the birth of a child and to care for the newborn within one year of its birth, (2) for placement with the employee of a son or daughter for adoption or foster care and to care for that child within one year of placement, (3) to care for the employee’s spouse, son, daughter, or parent with a serious health condition, or (4) when a serious health condition makes the employee unable to perform the essential functions of the employee’s job. There are special provisions for members of the military, certain airline employees, and their families.

**Q:** What does the Act mean by the term ‘eligible employee’? How do I determine if my office manager is one?

**A:** In order to benefit from the FMLA, he must have been employed by you for at least one year, have been employed at least 1,250 hours during the year immediately preceding the requested leave, and must be employed at a worksite “where 50 or more employees are employed by the employer within 75 miles of that worksite.”

**Q:** Am I a “covered employer”?

**A:** For the provisions of the FMLA to apply to a private employer, you must employ 50 or more people for 20 or more weeks during the current or preceding calendar year.

**Q:** Do we have to pay for his health care benefits while he is on leave?

**A:** You must maintain those benefits during his leave as if he were reporting to work on a regular basis.

**Q:** You mentioned that the Act applies if an employee or their son or daughter has a “serious health condition.” What is a serious health condition?

**A:** “Serious health conditions” include pregnancy, situations that require an overnight stay in a medical facility, and instances that incapacitate the employee or their affected family member for more than three consecutive days and require ongoing medical treatment. The Act specifically states that unless complications arise, “the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine” and routine dental problems do not qualify for FMLA leave.

**Suggested topics**

If you have any suggestions for topics to be discussed in this column, please email them to dweditor@aad.org.

See the February 2013 issue of Dermatology World for disclaimers.
**Q:** When our office manager returns, do I have to offer him the same position?

**A:** You are required to reinstate him in the same position he held when he took leave or to a similar position with equivalent salary, benefits, and other conditions of employment.

**Q:** It will be very hard for us to keep his position open. His role is very critical to our practice.

**A:** If he is among the highest paid 10% of all the employees, he may be considered a key or highly compensated employee. In that case, if you can show that restoring him to his prior position would cause “substantial and grievous economic injury” which would threaten the economic viability of your practice, you may be able to deny restoring him to his previous position. This is, however, a very stringent test. If you anticipate not restoring him to his previous position there are particular requirements, such as written notification, that must be met.

**Q:** My office manager has accrued a significant amount of paid leave. Can he take paid leave under the FMLA?

**A:** The FMLA requires only that the employee be given the opportunity to take unpaid leave. It does, however, permit an employee to elect (or an employer to require) the use of paid leave subject to certain specific conditions.

**Q:** Do I have to be concerned about state laws?

**A:** Yes. Many states have labor laws that have lower thresholds for determining an eligible employee or covered employer and/or broaden the range of covered conditions. If state laws mandate broader or more inclusive coverage of employees, those state laws must be followed.

**Q:** What else should I be aware of?

**A:** As an employer covered by the FMLA, you are required to post a notice informing employees of the Act in a conspicuous place. This should also be mentioned in your employee handbook. Finally, because the FMLA contains many nuances and exceptions to its provisions, please keep me informed so that I can make sure you are in compliance.

**Q:** If my office manager has any questions, where can I refer him to get answers?

**A:** The FMLA is administered by the Wage and Hour Division of the Department of Labor. They can be reached at (866) 487-9243. dw
Get ready for MIPS in 2019

BY FAIZA WASIF, MPH, MANAGER, PRACTICE MANAGEMENT

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

CMS has made several changes to the 2019 Merit-based Incentive Payment System (MIPS). While CMS did not finalize any sweeping changes to the program, dermatologists should be aware of changes to MIPS weights and scoring, the low-volume threshold exemption, and other provisions that will impact reporting in 2019. Here are the highlights.

**Payment adjustment**
The penalty for not participating for 2019 will go up to 7% (up from 5% in 2018) as required by law. See the full program timeline below.

**MIPS program timeline**

The image above depicts the timeline for the MIPS program outlining the reporting year, the year when incentives/penalties would be applied, and the amount of potential incentive/penalty.

**Eligible clinicians**
There is also an opportunity to opt-in to MIPS, allowing some clinicians — who otherwise would have been excluded under the low-volume threshold — the option to participate in MIPS. Eligible clinicians or groups will be able to opt-in if they meet or exceed at least one or two, but not all three, of the low-volume threshold criterion.

<table>
<thead>
<tr>
<th>Previous years</th>
<th>Added in 2019</th>
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<tbody>
<tr>
<td>Physician</td>
<td>Physical therapists</td>
</tr>
<tr>
<td>(including doctor of medicine, doctor of osteopathy, osteopathic practitioner, doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, doctor of optometry, and chiropractor)</td>
<td></td>
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<tr>
<td>Physician assistant</td>
<td>Occupational therapists</td>
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<tr>
<td>Nurse practitioner</td>
<td>Qualified speech-language pathologists</td>
</tr>
<tr>
<td>Clinical practitioner</td>
<td>Qualified audiologists</td>
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<tr>
<td>Certified registered nurse anesthetist</td>
<td>Certified nurse-midwives</td>
</tr>
<tr>
<td>Clinical social workers</td>
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</tbody>
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Eligibility criteria
The low-volume exemptions are as follows:
• Bill ≤ $90,000 in Part B allowed charges for covered professional services, OR
• Provide care to ≤ 200 Part B enrolled beneficiaries, OR
• Provide ≤ 200 covered professional services under the Physician Fee Schedule
Note: The first two criteria remain the same as 2018, and if you meet any of those criteria you are exempt from participation and will not receive a penalty nor be eligible for an incentive. There are two determina-

2019 MIPS reporting options for small practices (15 or fewer providers)
Note: The MIPS program includes all payers – not just Medicare.

<table>
<thead>
<tr>
<th>Participation</th>
<th>Reporting option without an EHR</th>
<th>Reporting options with an EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding the 7% penalty: 30 points minimum</td>
<td>• 5 quality measures one time each (between Jan. 1 – Dec. 31, 2019) PLUS 6 bonus points for small practice to numerator PLUS • 1 high-weighted Improvement Activity (for 90 consecutive days; last day to begin participation Oct. 2, 2019) TOTAL POINTS ACHIEVED: 30.75</td>
<td>• 1 high-weighted Improvement Activity for all eligible patients for 90 days (last day to begin participation Oct. 2, 2019) PLUS • 3 Promoting Interoperability measures TOTAL POINTS ACHIEVED: 32.5</td>
</tr>
<tr>
<td>Achieving minimal incentive: 31 – 74 points</td>
<td>• 4 quality measures that are not topped out for all eligible patients for the full year (Jan. 1 – Dec. 31, 2019) PLUS • 2 quality measures that are not topped out for all eligible patients for the full year (Jan. 1 – Dec. 31, 2019) PLUS • 1 high-weighted Improvement Activity (for 90 consecutive days; last day to begin participation Oct. 2, 2019) TOTAL POINTS ACHIEVED: 34.5</td>
<td>• 1 quality measure one time each (between Jan. 1 – Dec. 31, 2019) PLUS • Add 6 bonus points for small practice to numerator PLUS • 4 Promoting Interoperability measures for all eligible patients for 90 days (last day to begin participation Oct. 2, 2019) PLUS • 1 bonus measure TOTAL POINTS ACHIEVED: 34.25</td>
</tr>
<tr>
<td>Achieving maximum incentive (up to 7%): 75+ points</td>
<td>• Apply for and be approved for EHR hardship to have this category re-weighted to the Quality category PLUS • 5 quality measures that are not topped out for all eligible patients for the full year (Jan. 1 – Dec. 31, 2019) PLUS • 1 high-weighted Improvement Activity (for 90 consecutive days; last day to begin participation Oct. 2, 2019) TOTAL POINTS ACHIEVED: 80.3</td>
<td>• 3 quality measures that are not topped out for all eligible patients for the full year (Jan. 1 – Dec. 31, 2019) PLUS • 4 Promoting Interoperability measures for all eligible patients for 90 days (last day to begin participation Oct. 2, 2019) PLUS • 1 high-weighted Improvement Activity (for 90 consecutive days; last day to begin participation Oct. 2, 2019) TOTAL POINTS ACHIEVED: 79.5</td>
</tr>
</tbody>
</table>

DataDerm™ for MIPS reporting
Learn more about how DataDerm can help with MIPS reporting at www.aad.org/dataderm.
tion periods CMS assesses to determine if you met these criteria:

- An initial 12-month segment beginning on Oct. 1, 2017, to Sept. 30, 2018; and

Eligibility can still be confirmed on the QPP website in early 2019 (once it is updated by CMS): [https://qpp.cms.gov/participation-lookup/](https://qpp.cms.gov/participation-lookup/).

**Performance thresholds**

The thresholds to avoid the penalty or achieve an incentive have changed. The minimum score to avoid the penalty is 30 points, up from 15 points in 2018, and the minimum score to achieve the maximum incentive is 75 points, up from 70 points in 2018.

**MIPS in 2019**

Avoid the penalty = 30 points  
Eligible for maximum incentive = 75 points

**Reporting types**

Eligible clinicians will be able to continue to report individually, as groups, or virtual groups. **Note:** For the 2019 performance period, the virtual group election period closed on Dec. 31, 2018. In order to participate in MIPS as a virtual group, an election must have been made prior to the start of the performance period and can't be changed once the performance period begins.

**Performance categories**

The performance categories remain the same in 2019: Quality, Improvement Activities, Promoting Interoperability (previously Advancing Care Information), and Cost.

However, the weights for two out of the four categories have changed:

- Quality reduced to 45% in 2019 from 50% in 2018
- Cost increased to 15% in 2019 from 10% in 2018

**Improvement Activities and Promoting Interoperability** remain at 15% and 25% respectively.

**Performance periods**

- Quality: 12-month calendar year
- Cost: 12-month calendar year
- Promoting Interoperability: 90 days minimum
- Improvement Activities: 90 days minimum

**Small practice accommodations**

Several accommodations remain for small practices (15 or fewer providers) including:

- Claims-based reporting for the Quality category
- 3 points awarded per quality measure just for reporting
- 6 bonus points added to numerator of the Quality category (instead of the 5-point bonus added to the overall MIPS score from 2018)

**Extreme and uncontrollable circumstances**

CMS will automatically reweight the Quality, Improvement Activities, Promoting Interoperability, and Cost performance categories for MIPS-eligible clinicians who are affected by extreme and uncontrollable circumstances affecting entire regions or locales. To apply, visit [https://qpp.cms.gov/mips/exception-applications](https://qpp.cms.gov/mips/exception-applications).

Watch for the full details of the new rule as well as reporting options and interactive tools coming soon to the AADA Practice Management Center at [www.aad.org/macra](http://www.aad.org/macra).
Behind the lens

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Each month, Dermatology World addresses issues “in practice” for dermatologists. This month Dermatology World talks with Alan Gardner, MD, about his success as a fine art photographer and how he applies ‘the art of seeing’ to his work as a dermatologist.

“Art goes right along with dermatology. The face is like a landscape. You have hills and valleys. There are ways of composing photos to make them consistent and aesthetically appealing, and I use the same approach with my cosmetic practice.”

Picking up photography was a natural fit for a dermatologist, says Alan Gardner, MD, of Marietta, Georgia. “I like beauty; I like seeing things,” he explains. “It’s what I call ‘the art of seeing.’ When I come up with a composition, I’m looking at colors, textures, patterns, leading lines — things that will take you from one part of the photograph to another.”

The same concept, he says, is easily applied to dermatology. “Art goes right along with dermatology. The face is like a landscape. You have hills and valleys. There are various ways of composing photos to make them consistent and aesthetically appealing, and I use the same approach with my cosmetic practice. Using the basic rules of photography adds to my ability to create and bring out the natural beauty of my patients without giving them an overworked, unnatural look.”

As a self-taught photographer with more than a decade of experience, Dr. Gardner’s artistic practice has crossed over with his clinical work in more ways than one. “I started hanging my work in the office, because one, you know, it makes it pretty, but having them in the office makes patients more relaxed. They enjoy seeing the art and talking with me about it,” he says. “It’s taking us beyond just a doctor and someone who is coming in because they’re sick — we talk about their concerns from a dermatologic point of view, but when we talk about photography, it develops a more personal relationship.”

Patients are so fond of Dr. Gardner’s work, in fact, that there were some complaints following a temporary absence of artwork during an office remodel. “The first few months we didn’t have anything on our walls, and the patients were judging,” recalls Dr. Gardner. “‘Where are your photos? You better hurry up. I didn’t come here for nothing!’ It was kind of funny, so we started putting them up again. It’s been a really fun experience, which is what I want. I don’t want a stuffy office.”

Capturing the perfect photo

As any professional or amateur photographer knows, capturing the perfect image goes far beyond a simple point-and-shoot. Ratios, lighting, and color all must be considered, and one’s technical equipment is only as good as their knowledge of how to use it. “I focus strongly on composition so people will take time to look and study the pictures,” says Dr. Gardner of his style.

Dr. Gardner’s at-home printing studio has also allowed him further creative control over this artistic process. “I do all the printing myself on a large-format printer, which has made me very meticulous about how I shoot things,” he says. “I’ll print on various mediums such as fine art canvas, and museum-quality papers such as Hahnemuhle Baryta.”

Casting call

Do you know a dermatologist with a unique hobby or pastime? Are you one yourself? Email your suggestion to dweditor@aad.org. You could be featured in a future issue of Dermatology World.
Dr. Gardner with members of his staff.

On canvas, I can get a very rich, painterly-like effect, which sometimes I’ll do to give it more a dreamy kind of look.”

Primarily shooting with just two cameras, a Nikon D800 and a Phase One 100MP medium format, Dr. Gardner has a clear favorite in the latter. “It has a larger sensor and more megapixels, so the color, depth, and resolution I can get is absolutely incredible,” he says. Despite the strength of his lenses, Dr. Gardner is no stranger to marathon editing sessions in Photoshop to get the perfect final product. “I spend hours per picture working them up,” he divulges. “Photoshop gives me tremendous control when editing my photographs. I’m able to create whatever mood or emotion I want the viewer to feel.”

Having had the opportunity to shoot photos all over the world, among some of Dr. Gardner’s favorite subjects are natural landscapes and wildlife photography. “I enjoy getting into Cypress lakes, especially when the fall colors come, because you get these beautiful reflections that make it almost like a piece of abstract art when you see it,” he says. These nature studies have earned some high accolades over the years — coveted recognition by National Geographic as one of the top photos of the year in 2009, and two recent gold medals in the PX3 (Prix de la Photographie, Paris), one of Europe’s largest photo competitions, for a series of high-detail white egret portraits. When not submitting his work for competition, Dr. Gardner has also shown his work professionally across the United States. “I’ve been in a couple galleries here in Atlanta,” he says. “I was also featured in an exhibition last year at the Florida Museum of Photographic Arts.”

The art of giving back

This past year, Dr. Gardner recently took his photography a step further, holding an auction of his work at his practice to raise funds for the Skin Cancer Foundation. Inspired by patient interest in purchasing prints of his photography, he saw an opportunity to give back to a good cause. “Occasionally patients will ask if they can purchase a photo, and I thought, why don’t we have a big art exhibit, and donate the proceeds?” After several months of planning, the practice was temporarily converted for one Saturday into a pop-up gallery. “We had food, tables, a lady playing a harp, an ice sculpture,” says Dr. Gardner. “It was really fun, and a nice opportunity for patients to purchase a piece of art and at the same time make a donation that’s going to help other people.” Overall the event was a success, with several hundred attendees. “It was such a nice way to spend the afternoon. It makes things more personal. I want patients to feel like they’re family.”

Dr. Gardner’s photography on exhibit at his practice.

Alan Gardner, MD, is a dermatologist in Marietta, Georgia. View more of his photography at https://alangardnermd.smugmug.com.

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How to protect yourself from physician identity theft
In 2017 alone, there were 16.7 million victims of identity fraud, according to data from Javelin Strategy & Research — a record high in a country seemingly saturated with cybersecurity breaches. While each new news item gives the impression that anyone with a credit card, Social Security number, or access to the internet (essentially all of us) is susceptible, physicians in particular should be aware of the unique risks they face by not properly safeguarding their personal information. “While physicians suffer some of the same concerns about identity theft as everyone else, there are unique issues doctors face in regard to this issue,” said David Goldberg, MD, JD, a dermatologist and lawyer in New York.

Aside from the potential value of physicians’ unique medical identifiers, which can be used to fraudulently bill public or private payers for fake medical goods or services, physicians have other attributes that make them particularly attractive targets to identity thieves. “We frequently have discussions about this with high-wealth individuals, and physicians obviously fall into this category,” said Bob Watts, CEO of Vivitec, a national IT and cybersecurity firm. “The first thing you want to consider is what are these people after? As it relates to personal information, most of the time they’re after money.”

Aside from the potential financial impact, physician victims of identity theft can face additional consequences in the form of steep legal penalties — and even jail time — if they are found to have been negligent with their personal information due to the far-reaching consequences of medical fraud. How, therefore, can dermatologists navigate the risks to keep themselves — and their personal information — secure? This month, *Dermatology World* consults with legal and technical experts to discuss:

- What physicians can do to protect themselves
- What to do if your identity is stolen
- How to protect patients’ identities >>
THAT’S NOT ME!

How to protect yourself
While some of society’s seemingly mightiest institutions — credit bureaus, major corporations, hospital systems, political parties — have proven vulnerable to unsavory data miners, dermatologists need not consider personal loss from identity theft an inevitability, suggested Watts. “We’ve had hundreds of conversations with physicians around personal privacy and the current state of personal information breaches,” he said. There are proven, proactive steps physicians can take to keep their assets and personal information secure that include:

1. Invest in a monitoring service. “You could think LifeLock, or IDAgent. Those are the types of services that are going to monitor Social Security numbers, email credentials, bank accounts, who is trying to interact with your credit scores in any way,” said Watts.

2. Go beyond basic email. “It’s really time for folks to progress beyond a simple, unfiltered, unprotected, email solution,” said Watts of free email services from Google, cable companies, hosting providers, etc. While in the past, hackers who gained access to a victim’s inbox would perhaps spam their contacts list with fraudulent emails seeking sensitive information or money, recently identity thieves have begun taking a more nuanced approach. “Within the last nine months, we’re seeing that they’re very discreetly sending the emails back to a server and they go through them for more social engineering. They’re looking for communication with a financial planner or bank, anywhere they can pick up account information or contacts to try to get money transferred,” he explained. In order to avoid falling victim to what is quickly becoming a billion-dollar crime enterprise, physicians should follow some essential email best practices: Frequent password changes, multi-factor authentication, an email address tied to a trusted domain, security settings, and filtering.

3. Keep it “clean.” “If you’re doing anything related to money movement or money transfers, make sure you use a computer that you know is clean, has frequent OS and antivirus updates, and has a firewall installed on it,” advised Watts. This also involves avoiding potentially unsecured internet connections — including anywhere from hotel lobbies to the local Starbucks. Kids too, can potentially compromise a previously secure device. “Don’t use the same computer that the kids surf the internet on every night at home. You want to use a machine where you have confidence that it’s protected — and this applies to mobile devices as well,” said Watts.

4. Don’t be afraid of the dark. Well-known as the seedy underbelly of the internet, periodic dark web scans can help give physicians peace of mind that their information isn’t being held for auction to the highest bidder. “It’s amazing how many credentials we find being bought and sold on the black market today,” said Watts. “There are a variety of services available for that, but you want to have one specifically scanning for your email and Social Security number to see if there is private information or passwords being sold and traded.”

5. Be a little paranoid. “Folks in general need to be more suspicious than they have in the past,” said Watts, who suggests physicians and their staff take basic steps to improve their cybersecurity proficiency. “That can come in the form of reading a little bit more about cybersecurity, like this article. Or taking training about how to review emails and attachments, and really thinking before you engage with an unknown attachment, link, or website.”

The conundrum of medical identifiers
“NPIs have become an integral part of health care providers’ medical identities, much like a Social Security number,” explained Zenobia Harris Bivens, JD, in a 2018 Physicians Practice article. “This also means that, like a Social Security number, an NPI is vulnerable to identity theft. This is primarily because NPIs are not confidential. Your NPI is publicly available on the National Plan and Enumeration System.”

As a sensitive, key component of the modern medical system — that’s available on public domain — preventing theft of medical identifiers poses a unique challenge to physicians who can be subject to major civil and criminal penalties if they are misused. “With NPI, that’s most commonly stolen through cyberspace, but can be stolen from “real space” as well,” explained Dr. Goldberg. “The problem is obviously that NPI numbers are used by all physicians to bill for Medicare
In the event of fraud, the penalties to physicians can be steep. Fraudulent billings to non-government insurance typically result in civil lawsuits, and Medicare or Medicaid fraud can land potential jail time. “Fraud is a big deal. The physician might claim, ‘well, it wasn’t me,’ but then they’re going to have to answer how it was that someone obtained that NPI number,” said Dr. Goldberg. “Was it obtained in a way that could have happened to any of us? Or did it occur because the physician didn’t have appropriate security installed in their computer systems, or left the NPI number on the front desk?”

Given the significant time and expense associated with defending a charge of billing fraud in the event of stolen physician identity, being proactive is often the best defense. “A case like this is not going to be covered by medical malpractice insurance, and it’s not going to be covered by your home umbrella policy. You’re on your own with this,” cautioned Dr. Goldberg.

What can physicians do to avoid these consequences? Adopt a bit of a lawyer’s perspective. “NPI is out there and vulnerable, but much like everything else we do with patients, there are levels of protection available.”

All medical practices contain a veritable treasure trove to cyber thieves: Patient data. From sensitive personal information contained in health records to stored credit card information obtained during check out, data stolen from both major health care systems and small independent practices alike are a hot commodity on the internet black market, suggested Bob Watts, CEO of Vivitec. “While the prices come down in bulk, it can be anywhere between $65 to $100 per verified medical record. Medical records have Social Security numbers, account numbers, personal history, and may include maiden names. You can imagine what kind of accounts you can set up or replicate with that information.”

What can physicians do to ensure that their patients’ data is kept safe? “Physicians really ought to think about cybersecurity as a specialty of technology and not all-encompassing. It’s time for them to have a cybersecurity specialist and an IT provider,” said Watts, who recommends practices screen for a firm with advanced skills that go beyond installing a firewall or installing anti-virus. Additionally, staff education surrounding cyber security best practices, and having a general working understanding of how patient records and images are stored, are important steps. Whether practices store information in-office on a server, through cloud-based means, or through a service provider, “How you are protecting that information is an important consideration for any physician, as well as how you’re sending medical information,” said Watts. From a cybersecurity — and HIPAA — standpoint, protected health information (PHI) should only be sent via encrypted means. (For more on cybersecurity and how it relates to HIPAA compliance, read Dermatology World’s February 2018 feature “Cyber hacking in health care” at www.aad.org/dw/monthly/2018/february/cyber-hacking-in-health-care).

Dermatologists should also consider adopting additional security monitoring in the form of either a SIEM (Security Incident Event Management) service or MDR (Managed Detection Response) system. “Many of the practices we’re working with have realized that it’s time and are adding security monitoring systems,” said Watts. “These systems will basically be the ‘eyes’ looking for any type of unusual event that might get onto the network, a server, a workstation, or even onto applications. If someone gets past the basic defense, these are going to trigger the alarm.”
know of a case where staff had access to a physician’s NPI number, and a relative of one of the staff members set up a fraudulent billing system and billed Medicare for literally millions of dollars,” said Dr. Goldberg. “The physician involved claimed no liability because he didn’t do it — but in the end he settled because the NPI number was not protected in a reasonable manner.”

Physicians are additionally advised to take particular care regarding their NPI information when changing practice locations or switching organizations. A 2012 JAMA article described one unfortunate case of a physician who gave his information to the wrong potential employer: “Nearly two years after sending out job applications, he was asked by Medicare to return more than $350,000 in overpayments made to a practice he had interviewed with but never joined.” To avoid this fate, the authors recommend that, “Physicians should update payers about material enrollment changes, especially when opening, closing, or moving practice locations, or separating from organizations” (JAMA. 30(5): 459-460).

Other precautionary measures involve frequently monitoring claims and reimbursements to verify that billed services match a physician’s actual income. “If it does not match up, that is an indication that someone is diverting your reimbursements to a bogus address,” said Bivens.

Ultimately, Dr. Goldberg recommends physicians treat their medical identifiers the same way as they would their credit card number. “I’ll never write my credit card number in an email and send it to somebody,” he explains. “Applying for hospital privileges, I’ve had an administrator send me an email asking for my NPI number. There’s no way I’ll ever do that unless it’s through a secure type of email system.”

Beyond billing, fraudulent prescriptions can create another area of liability for physicians, particularly as sensitivity regarding the nation’s ongoing opioid crisis nears its zenith. While most physicians have policies in place to secure paper prescription pads, with e-prescribing on the rise, how can doctors monitor who is able to dispense under their name? The first step is to clearly designate, in writing, which specific staff members are permitted to prescribe, said Dr. Goldberg. “That’s the only way you can protect yourself. You can never stop this stuff totally, but there are ways you can control it.” Failure to do so can, predictably, also result in lawsuits, penalties, and, in extreme situations — culpability in homicide. “There’s an ongoing situation involving e-prescribing, where a relative of a staff member was able to obtain narcotics. The relative then took the narcotics and was involved in a car accident where someone was killed. There is now an allegation of negligent homicide against the physician involved,” said Dr. Goldberg. “If I don’t have rules in place, everybody in my office is able to e-prescribe, and if something like this happens, it’s going to be a real big mess.”

Your identity has been stolen. What next?
The worst has happened, an identity thief has stolen your information. What are your next steps?

1. **Compile information and evidence.** If you suspect someone has stolen your personal information, start reviewing your records for inconsistencies. Check your credit report for unfamiliar accounts or charges, or odd bank account withdrawals. If you believe your NPI has been compromised, check billing files or patient files related to the fraudulently billed services.

2. **Report.** In the event someone has attempted to file a false tax return on your behalf using your Social Security number, it’s likely you won’t be aware until the second return is filed — either you or the person who has stolen your information. If this occurs, you should immediately contact the IRS using IRS form 14039. Following this, you should consider placing a fraud alert and credit freeze on your credit report to prevent any unauthorized accounts from being opened, in addition to contacting the Federal Trade Commission and filing an identity theft police report.

If someone has stolen your NPI information, “You have to notify all the insurance companies that you have contracts with. You have to notify your state board of medical examiners, and you have to notify your medical malpractice insurer,” said Dr. Goldberg. Physicians are also advised to contact CMS as soon as possible if they suspect NPI theft.

3. **Start remediation process.** In addition to seeking out identity-recovery services, victims of identity theft may want to consider obtaining legal counsel in the event of any future lawsuits depending on how the stolen information is used. In response to increased concerns regarding NPI identity theft, CMS launched the Center for Program Integrity (CPI) in 2011 to assist victims and aid in recovery and exoneration. More information and resources are available at [www.cms.gov/About-CMS/Components/CPI/CPI-Landing.html](http://www.cms.gov/About-CMS/Components/CPI/CPI-Landing.html).
Medical financing promotions

Debt consolidation promotion
3.89% for the first three years\(^1,2\)
- Pay off high interest rate business loans, and consolidate into one loan
- Flexible loan terms up to 15 years to improve cash flow of practice
- You’ll also get a competitive rate through maturity, and you’ll know the rate up front
- Debt consolidation applications beginning September 17, 2018 through November 30, 2018. Loan must close by December 31, 2018

Practice acquisition promotion
0% for the first six months\(^1,2\)
- Eligibility includes practice acquisition, partnership buy-ins, and second location purchases
- Flexible loan terms up to 15 years to improve cash flow of practice
- You’ll also get a competitive rate through maturity, and you’ll know the rate up front
- Practice acquisition applications beginning September 17, 2018 through November 30, 2018. Loan must close by December 31, 2018

Commercial real estate promotion
1.99% for the first six months\(^1,3,4\)
- Loans from $100,000 to $2,500,000
- We’ll pay your appraisal fee when you close a commercial real estate loan\(^3,4\)
- 1.99% interest rate for the first six months and then a competitive rate through maturity\(^4\)
- Applications beginning September 10, 2018 through October 31, 2018. Loan must close by January 31, 2019

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LEFT in the DARK

An explanation to patients on the factors that can keep physicians out of the loop on current drug prices and costs to patients
Dear Dr. Dermatologist,

I am deeply concerned about a recent prescription you gave me for my skin condition. I went to the pharmacy and found out that I had to pay a lot more than I was expecting! Why would you prescribe a drug that costs so much?

Regards,

Discouraged Patient

Dear Patient,

I am sorry that the medication I prescribed costs much more than you expected. Retail prices for medications and insurance coverage can vary drastically, so prescribers often don’t know how much any one patient will be charged.

Unfortunately, it is not uncommon for physicians to be left in the dark on drug prices. Let me explain...
In recent years, wholesale and retail drug prices have skyrocketed in the U.S. According to the American Academy of Dermatology’s (AAD) 2016 Burden of Skin Disease Report, prescription drug spending within dermatology doubled from $7.4 billion in 2004 to $14.9 billion in 2013 (doi: 10.1016/j.jaad.2016.12.043). According to Maryam Asgari, MD, deputy chair of the AAD’s Drug Pricing and Transparency Task Force, some of these drugs have been on the market for decades and were inexpensive up until the last few years. For example, the average retail price for a 30g tube of clobetasol ointment — a common topical corticosteroid used to treat inflammatory skin conditions — was $36.30 in 2005 and $276.90 by 2016 (doi: 10.1016/j.jaad.2018.03.004). That’s a price that’s out of reach for many patients.

Generic drugs are no longer necessarily cheaper than their brand name equivalent. According to a 2016 U.S. Government Accountability Office report that tracked pricing trends for generic drugs under Medicare Part D, several generic dermatology drugs increased in price at least 100% or more between 2010 and 2015. Daniel Bennett, MD, member of the AADA’s Drug Pricing and Transparency Task Force, indicated that many generics are made by only one or two manufacturers. This gives them strong pricing power in the marketplace and allows them to drive up costs.

To his point, a cost analysis of 116 topical dermatologic generic drugs showed an inverse correlation between drug price and number of manufacturers (doi: 10.1001/jamadermatol.2018.3798). Drugs with one to two manufacturers sustained a 33.2% higher median percentage price increase than did drugs with more than six manufacturers. Policies that increase market competition among topical dermatologic drug manufacturers may lead to long-term price reductions.

Drug shortages also contribute to price spikes. According to Dr. Bennett, when only a handful of manufacturers make both the brand name drug and its generic equivalent, it sets up a scenario for drug shortages, which can drive up the cost in very unpredictable ways. Joerg Albrecht, MD, chair of the AADA’s Drug Pricing and Transparency Task Force, said that we used to have many inexpensive, generic “go-to” drugs, but shortages have forced the prices of those drugs to rise higher and higher. Unfortunately, Dr. Albrecht said that price hikes due to shortages that occurred three to four years ago haven’t come down yet. The GAO report I mentioned confirms this, noting that the cost of the generic dermatology drugs that experienced extraordinary price increases persisted for at least one year and most did not show any downward movement.

Prior authorization help
Easily create appeal letters to help overturn denials for prior authorizations. Check out the AADA’s Practice Management Center at www.aad.org/practicecenter/managing-a-practice/prior-authorization-assistance.

Unfortunately, it is becoming harder and harder for physicians to keep up with the price of medications. I frequently use my electronic health record to get a sense of the cost of the drugs that I prescribe and whether it is listed on my patients’ insurance coverage. However, it doesn’t tell me what your out-of-pocket cost will be and only offers a general idea of the cost of the drug.

Finally, what you pay for a drug depends heavily on your health insurance, and whether your coverage requires a copay or has a deductible for medications. Insurers are increasingly implementing coinsurance, requiring patients to pay a percentage of the cost out of pocket rather than a flat rate. Some policies do not cover prescription medications at all. Many insurers have restricted formularies and a medication that is not on this list can be very expensive. Insurance companies negotiate medication costs with drug manufacturers, and some receive
incentives and rebates, both of which affect the price of the drugs to you. They renegotiate every year, which can result in changes to the cost and even the medications that are available to you in their formularies. Physicians are not privy to this process and we may not know about changes until you or the pharmacy call us.

There are a few things we can do together that may help.

For starters, shopping around might save you money. Drug prices can vary significantly from one pharmacy to another. One option, says Dr. Albrecht, is to search around for your prescribed medication on sites like covermymeds.com. However, purchasing different medications at different pharmacies can be a double-edged sword because while it may lead to lower costs, patients should be cautious about potential adverse drug interactions. Pharmacists are trained to identify drug interactions, recognize when a drug is contraindicated, and counsel patients about side effects. However, if you get multiple prescriptions from different pharmacies, the pharmacist may not know about your other medications and potential interactions. This is something you should be aware of, and you should check for potential adverse drug interactions if you go this route.

You may have also heard about the option of a “specialty pharmacy.” Elaine Siegfried, MD, member of the AADA’s Drug Pricing and Transparency Task Force, has worked with specialty pharmacies that help with prior authorizations and identify patient assistance programs that provide lower cost or even free drugs for patients.

If those options don’t work, we may be able to get some medications through a patient assistance program if offered by the drug manufacturer. According to Dr. Bennett, these programs allow some patients to get the medication for a lower cost, but often only for a limited amount of time. Dr. Siegfried has found that applying for these programs can be time-consuming and difficult, and they are only available for medications prescribed for the exact condition and age group approved by the FDA.

On a positive note, your pharmacist can now tell you if it is cheaper for you to pay cash for your medications instead of paying the co-pay. Previously, pharmacists were not allowed to do this because of what was known as a “gag clause” that gave insurance companies control over what the pharmacist could say to you. In 2013, 23% of 9.5 million prescriptions filled through insurance ended up costing patients more money than if they paid out of pocket (JAMA. 2018;319(10):1045-1047). The overpayments totaled $135 million!

Fortunately, in October the Know the Lowest Price Act and the Patients Right to Know Drug Prices Act were signed into law — covering private insurance and Medicare Part D respectively. The laws eliminate the gag clause that prohibited pharmacists from telling patients if the cost of their medication would be less expensive if they paid out of pocket instead of using their insurance. You should know, however, that the pharmacist is not required to tell you this, so you must ask them directly.

In the future, if you learn that a medication is too costly, do not fill the prescription. Please call me so we can discuss other options. If necessary, my staff can call the insurance company to find their preferred alternative or ask about the possibility of submitting documentation to help authorize coverage for our first choice.

It’s important that we work together to find the most affordable and effective medication to treat your skin condition. I appreciate your coming to me with your concerns.

In health,

Dr. Dermatologist

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**Patient resources**

The Academy offers physicians and patients several resources to help navigate formulary restrictions. Check out these tools and resources at [www.aad.org/practicecenter/managing-a-practice/prior-authorization-assistance/prior-authorization-patient-resources](http://www.aad.org/practicecenter/managing-a-practice/prior-authorization-assistance/prior-authorization-patient-resources).
JOINING FORCES

Collaboration and diverse expertise strengthen clinical practice guidelines
Dermatologists look to the AAD’s clinical practice guidelines to serve as a roadmap for providing evidence-based care. In the past, guidelines for members have been developed within the Academy, following a painstaking multi-year process that begins with selecting a topic and ends with publication in the *Journal of the American Academy of Dermatology (JAAD)*. Now, the Academy is engaged with other organizations in developing new guidelines for psoriasis and for reconstruction after skin cancer resection.

*Dermatology World* looks at what the new and upcoming joint guidelines entail, as well as the challenges and benefits of the joint guideline development process.

**Psoriasis guidelines**

The most recent guidelines for the management of psoriasis were published in *JAAD* from 2008 to 2010. Almost 10 years later, the AAD has teamed up with the National Psoriasis Foundation (NPF) to develop a new set of guidelines, scheduled for publication in 2019. The guidelines will address six main topics:

- Comorbidities associated with psoriasis
- Biologic drugs used in psoriasis therapy
- Phototherapy
- Topical therapies
- Systemic therapies
- Pediatric psoriasis


The guidelines were updated in response to an urgent need for physicians to stay abreast of new developments in psoriasis therapy, including the growing arsenal of biologic drugs and the recognition of multiple comorbidities, said M. Alan Menter, MD, chair of the division of dermatology at Baylor University Medical Center and co-chair of the AAD/NPF Psoriasis Guideline Work Group. “When I travel internationally, many of my colleagues ask why the Academy hasn’t published new guidelines, given all that has happened in psoriasis in the last five to seven years,” Dr. Menter remarked.

A key issue in psoriasis therapy, he maintained, is that of the estimated 1.5 million patients in the U.S. with moderate-to-severe psoriasis, “one million are not receiving a systemic or biologic agent. That means we in dermatology have lagged far behind our colleagues in rheumatology — 90% of patients with rheumatoid arthritis or psoriatic arthritis are being treated appropriately with systemic therapy. The big question now is: Do sufficient numbers of our colleagues in dermatology recognize that we are now dealing with psoriasis as a systemic disease with multiple associated comorbidities?”

Comorbidities did not appear as a separate topic in the 2008 guidelines. However, a comprehensive guideline for 12 comorbid conditions is first in line for publication in JAAD.

“The societies each nominated two people to represent them, like Noah’s ark.”

Guideline development 101
Learn more about the guideline development process at www.aad.org/practicecenter/quality/clinical-guidelines/guideline-development-process.

Reconstruction guidelines
The impetus for developing clinical practice guidelines for reconstruction after skin cancer resection came from the American Society of Plastic Surgeons, which reached out to the AAD and three other specialty societies, said Murad Alam, MD, vice chair of the department of dermatology at Northwestern University’s Feinberg School of Medicine. Dr. Alam serves on the guideline committee as co-chair and representative of the American Society for Dermatologic Surgery. Other participating societies include the American College of Mohs Surgery and the American Society of Mohs Surgery.

“We thought it was more appropriate for dermatology and plastics to collaborate on the reconstruction part and not the removal part, because we really don’t remove things the same way but we both do reconstruction,” said Dr. Alam. “We tried to focus on issues that would apply to all reconstructions, like the appropriate use of antibiotics and blood thinners.” Another key issue the committee is addressing is postoperative pain management, “and we’ve taken into account a lot of the concerns about opioid addiction. We want to make sure that we’re providing guidance that helps and doesn’t exacerbate the situation.”

The AAD representative to the committee, Marta J. Van Beek, MD, chief of staff at the University of Iowa Clinics and Hospitals and director of the division of dermatologic surgery at the University of Iowa Carver College of Medicine, noted that as the committee members brainstormed topics to address, the final topics selected had evidence in the literature to substantiate recommendations, and had the larger safety risk profiles. “We wanted to make sure the first round of guidelines had the biggest impact on safety.”

First drafts of the guidelines have been circulated throughout the committee, and staff is now in the process of collating members’ comments on the drafts, Dr. Alam said. Publication is planned for 2019 in Dermatologic Surgery, Plastic and Reconstructive Surgery, and JAAD (pending AAD Board approval).

Negotiation and conflicts
While the new guidelines on psoriasis and reconstruction will be completed in 2019, where and how did the joint guidelines development process all start? The psoriasis collaboration originated with the NPF, which Dr. Menter said “was keen to be associated with our guidelines.” The AAD’s Clinical Guidelines Committee evaluates requests for collaboration and presents a recommendation to the Council on Science and Research. The council’s recommendation is then submitted to the Board of Directors for a final decision, said Vidhya Hariharan, manager of AAD clinical practice guidelines and research. If the Board approves
the collaboration, the organizations develop a memorandum of understanding.

Once the leadership of the five organizations involved with reconstruction agreed to proceed, “the societies each nominated two people to represent them, like Noah’s ark,” said Dr. Alam. “Those representatives negotiated the process, particularly the procedural aspects: How are we going to do this and what are our ground rules? The two co-chairs worked that out, and after that it was just a matter of everyone working together toward one common goal.” One key stipulation from the dermatology side, Dr. Alam added, was that “we really needed equal representation from dermatology and plastics. It wouldn’t be okay if there were nine plastic surgeons and one dermatologist. That was negotiated and then we went from there.”

Additionally, the Academy follows its Administrative Regulations for developing Clinical Guidelines, that emphasize that a minimum of 51% of workgroup members should not be conflicted. These regulations are adopted from the National Academy of Medicine standards and the Council of Medical Specialty Societies standards, Hariharan explained. One advantage to collaborating with the NPF, Dr. Menter said, is that they were able to provide patients and research grant recipients (with no conflicts) to serve on the committee, allowing the AAD to retain some of its top psoriasis experts who had worked with industry and still adhere to the 51% rule.

The rule didn’t present a major hurdle to the reconstruction guidelines committee, Dr. Alam said, “because we are cutting things with scalpels and sewing them with

In addition to working with other organizations to develop joint guidelines, the AAD has endorsed guidelines published for urticaria — from an international consortium — and food allergies — from the National Institute of Allergies and Infectious Diseases.

**Urticaria guidelines**

The AAD was one of 42 organizations from 25 countries to delegate a participant in the development of the 2017 update to the EAACI/GA2/LEN/EDF/WAO Guideline for the Definition, Classification, Diagnosis, and Management of Urticaria. The AAD also endorsed the final guideline, published in *Allergy* ([https://doi.org/10.1111/all.13397](https://doi.org/10.1111/all.13397)).

Highlights include:

- A diagnostic algorithm for chronic urticaria and recommendation of a limited workup rather than more extensive diagnostic screening tests
- The recommendation of second-generation H1 antihistamines as a first-line treatment for chronic urticaria
- A recommendation against the long-term use of systemic corticosteroids in chronic urticaria


**Food allergy guidelines**

Two dermatologists were among the panel of experts convened by NIAID to develop guidelines for the diagnosis and management of food allergy. The guidelines were published in 2010 in the *Journal of Allergy and Clinical Immunology* ([doi.org/10.1016/j.jaci.2010.10.007](https://doi.org/10.1016/j.jaci.2010.10.007)). NIAID published an addendum to the food allergy guidelines in 2017 to report the findings of its expert panel on the prevention of peanut allergy ([www.niaid.nih.gov/sites/default/files/addendum-peanut-allergy-prevention-guidelines.pdf](https://www.niaid.nih.gov/sites/default/files/addendum-peanut-allergy-prevention-guidelines.pdf)). The AAD endorsed both the 2010 guidelines and the addendum.

Highlights of the 2010 guidelines include:

- Discussion of skin reactions that are IgE-mediated (urticarial, angioedema, flushing, pruritis), cell-mediated (contact dermatitis, dermatitis herpetiformis) and mixed Ige- and cell-mediated (atopic dermatitis)
- Association of early onset severe atopic dermatitis with risk for sensitization to food
- A recommendation against using intradermal testing to make a diagnosis of food allergy

Highlights of the 2017 addendum include:

- Discussion of the findings of the LEAP (Learning Early About Peanut Allergy) clinical trial, which suggests that early introduction of peanut-containing foods could reduce the risk of peanut allergy in high-risk infants
- Three recommendations for infants at various risk levels: severe eczema and/or egg allergy, mild-to-moderate eczema, and no eczema or food allergy
- A recommendation against allergy testing for foods other than peanut

sutures. We’re not doing clinical trials for new drugs. There’s really not much of a conflict when it comes to using steel instruments.”

**Joint guidelines challenges and benefits**

When different medical specialties collaborate on a consensus guideline, “it gets tricky because the consensus in one specialty is not the same as the consensus in another specialty,” said Dr. Van Beek. “I see that in our institution’s multidisciplinary tumor board all the time. We’ll recommend a therapy and it won’t be in the ENT literature, and what they’re doing isn’t necessarily in our literature, and there can be contradictions because we’re looking at different subsets of patients.” Because of those complexities, she said, “if one group didn’t agree with the consensus, they could pull back from the guideline process. That’s what the negotiations were centered around.”

Dr. Alam noted that collaboration can be “logistically challenging because people are coming from different places — not just geographically, but in terms of their expectations and beliefs. Getting everyone on the same page and moving in the same direction requires trust, transparency, and perseverance.” The key division between the dermatologists and plastic surgeons was not so much technique as site of service, he pointed out. “We do much of our work in the outpatient setting under local anesthesia, and they do most of their work in the operating room under general anesthesia. That was a consideration that did come up repeatedly.”

On the plus side, establishing a consensus guideline among different medical specialties should lead to improved patient care, Dr. Van Beek maintained. “If we all have the same set of guidelines for post-cancer extirpation reconstruction, that’s generally more helpful to patients than if each specialty has its own guidelines. I do think there are some definite differences in the way that specialties do things, but if there’s literature to support a more common path forward, we all should be following that.” In addition, “joint guidelines have more weight with insurers. CMS — the ultimate insurer — looks more kindly on those, because they’re looking for more standardization. Regulatory bodies prefer that, and it’s better for patients.”

Whether joint guidelines carry more weight in the legal arena than those representing a single specialty is unclear. All AAD guidelines include a disclaimer warning that they should not be interpreted as setting a standard of care. However, Dr. Alam maintained that physicians writing the guidelines are generally careful to use the word “should” only when “you really mean you absolutely, definitely have to do something. Because we know that insurance companies and the government and courts have construed, in certain cases, parts of guidelines to constitute if not a standard of care, at least a suggested care approach.”

Developing clinical guidelines with another specialty requires more time, Dr. Alam said, because “there’s learning about each other’s views and how you approach things. Specialties are often very siloed.” However, taking the time and making the effort advances dermatologists toward a worthwhile goal, he said, which is “to create goodwill, grow the relationship, and help patients by developing recommendations that are widely accepted.”

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**Legally speaking**

LILLY FOR BETTER

The human race has always been curious, hopeful and resilient. Discovery is our purpose on this planet. It’s our calling and the spirit that’s defined Lilly since day one. After more than a century and nearly 100 medicines and countless innovations, we’re still searching for the next great discovery that will make life better for people around the world.

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Picture this: A sick patient comes in for your help. As an experienced dermatologist, you know exactly what to do and are confident your prescribed course of treatment will do the trick. The patient leaves with a renewed sense of optimism, and you go about your day knowing that you helped. But then you get a call from the patient. Their prescription is either not covered by their insurance, too expensive, or requires multiple layers of approval. None of us have trouble picturing this scenario, and in fact, it’s probably happened to each of us in recent history. It can be so utterly frustrating when you — the physician — know what’s best for the patient, yet the other players in health care aren’t willing to do their part. Fortunately, our specialty isn’t just sitting back and watching these access problems unfold.

We know all too well that restrictive insurance policies, such as prior authorizations and step therapy, are daily burdens for physicians, staff, and patients. However, the Academy has developed a number of resources to help, such as the prior authorization denial letter generator and other tools that help patients navigate prior authorizations (www.aad.org/practicecenter/managing-a-practice/prior-authorization-assistance/patient-letter-template), drug pricing, and step therapy issues.

Additionally, the advocacy arm of your Academy is actively pushing states to enact step therapy protocols (www.aad.org/advocacy/state-policy/step-therapy-legislation). Recently, 19 states have enacted step therapy laws. At the federal level, the AADA successfully advocated for legislation requiring CMS to create a standardized electronic process for Medicare prior authorizations for medically necessary drugs in Medicare Advantage and Medicare Part D participating plans. The AADA also successfully advocated for two laws — the Know the Lowest Price Act and the Patients Right to Know Drug Prices Act — that lift insurers’ ‘gag clauses’ that restrict pharmacists from informing insured patients when a drug is cheaper if paid out-of-pocket, covering private insurance and Medicare Part D respectively.

Onerous insurance policies aren’t the only issue plaguing our patients, as we continue to be adversely impacted by drug shortages — particularly lidocaine with and without epinephrine, sodium bicarbonate, and bacteriostatic saline. The AADA is engaged with stakeholders, including manufacturers, suppliers, the FDA, and Congress to facilitate access for patient care. In the meantime, the Academy has developed resources for physicians to navigate these drug shortages at www.aad.org/advocacy/drug-pricing-and-availability/dermatologic-drug-shortages.

To top it off, physicians could be facing onerous requirements for compounding sterile preparations if the United States Pharmacopeial Convention (USP) finalizes, and state pharmacy boards adopt, changes to USP’s chapter 797 compounding regulations. Recently, the AADA — along with the American College of Mohs Surgery, the American Medical Association, the American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery — met with USP, the FDA, and the CDC at an in-person meeting to discuss the need for patient access to in-office preparations in dermatology. Additionally, the AADA called on its members to write USP and oppose these new regulations, resulting in almost 900 letters. We are hopeful that our advocacy efforts will shine a light on the significant impact these regulations will have on dermatologists and patients.

To all of our rank and file Academy members: I thank you for taking the time and going to bat for your patients by heeding our calls to action. We need to keep up the pressure. We can only go so far in helping our patients get better if they can’t get access to the medications they need. As physicians devoted to providing quality patient care, we must continue to do our part to advocate on their behalf. dw

Chipping away at patient access hurdles

BY SUZANNE OLBRICHT, MD

AADA access resources

For more information and resources on patient access to medications, visit www.aad.org/advocacy/drug-pricing-and-availability.
Patients are paying more for healthcare. Dermatologists have more uncollected payments. We can help both of you.

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Visit us at the AAD Annual Meeting at Booth #1509.

*CareCredit Payment Benchmark Study with Enrolled Providers, conducted by Chadwick Martin and Bailey, December, 2016
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COMMITMENT

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What is the Academy doing to protect patient access to compounded medications?

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

As one of its top advocacy priorities, the AADA continuously advocates for physician relief from regulations and requirements impacting the practice of medicine, including compounding restrictions. Additionally, the Academy has developed several tools and resources to help physicians comply with compounding restrictions and access drug products that cannot be compounded in the clinical setting.

**Advocacy activities:**

Recently, the United States Pharmacopeial Convention (USP) issued proposed updates to its chapter 797 standards which outline equipment and process requirements for compounded sterile preparations, including those compounded in physician offices. USP proposed a one-hour exemption from the chapter’s requirements, which would require, for example, the administration of buffered lidocaine within one hour of preparation, otherwise the chapter’s standards would apply.

The AADA advocates against barriers that restrict patients’ access to compounded treatments. As part of its advocacy efforts, the AADA:

- Met with representatives from the USP, Food and Drug Administration (FDA), and Centers for Disease Control and Prevention (CDC) to discuss the need for patient access to in-office preparations in dermatology, specifically buffered lidocaine. The AADA was joined by the American College of Mohs Surgery, the American Medical Association, the American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery.

Want weekly updates on what the AADA is doing to advocate for you? Subscribe to the ‘Advocacy’ section of the Academy’s DW Academy Insider e-newsletter. Visit www.aad.org/account/communication and select ‘Advocacy’ under Dermatology World Academy Insider.
SOMETHING NEW IS APPROACHING

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Issued a call to action to Academy members urging them to contact USP with their concerns about its proposed revision, advocating for a longer time-exemption. In total, members sent 843 letters to USP.

Drafted sign-on letters and talking points to engage state dermatology associations and the Coalition of Skin Diseases.

Submitted an official comment letter to USP opposing the updates.

**Resources for physicians:**

The Academy offers several resources for physicians at its Practice Management Center. Here are a few highlights:

- Take a quick compounding quiz to determine if the type of compounding you are performing is in compliance with FDA regulations.
- Visit the AADA’s Compounding Toolkit to find out how you can access a drug product if it cannot be compounded or prescribed by you.

Check out these resources and more at [www.aad.org/practicecenter/managing-a-practice/compounding-toolkit](http://www.aad.org/practicecenter/managing-a-practice/compounding-toolkit).
There is a lot of valuable information covered at the 2019 AAD Annual Meeting, from ground-breaking research to the latest in patient care. Catch sessions you miss and review your favorites with 2019 Annual Meeting On-Demand Recordings.

To purchase:
Visit the AAD Resource Center in Hall D at the 2019 AAD Annual Meeting.
Friday, March 1 – Monday, March 4
8 a.m. – 5 p.m. daily

Or visit store.aad.org and use promo code DWODR19
Promo code expires March 31, 2019.
AAD mourns the passing of Stephen I. Katz, MD, PhD

The American Academy of Dermatology (AAD) has learned with sorrow of the passing of Stephen I. Katz, MD, PhD, on Dec. 20. Dr. Katz was an internationally respected physician, scientist, and administrative leader, as well as a pioneer in immunodermatology. In his 40-year tenure as a senior investigator and then chief of the National Cancer Institute Dermatology Branch, Dr. Katz trained and mentored numerous national and international academic dermatology leaders, many of whom have gone on to attain high-ranking positions at institutions around the world. Since 1995, Dr. Katz achieved great success as director of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). He was recognized with the Distinguished Executive Presidential Rank Award, the highest honor that can be bestowed upon a civil servant, for his contribution to the NIH. In recognition of his extensive leadership contributions to dermatology, both within and outside of the Academy, Dr. Katz received the Academy’s Gold Medal award in 2018 — the Academy’s highest honor. The AAD also named him a Master Dermatologist in 2005.

Dr. Katz was born in New York in 1941 and lived in the Washington, D.C. area. He graduated with honors from the University of Maryland and Tulane University Medical School. He completed a medical internship at Los Angeles County Hospital and did his dermatology residency at the University of Miami Medical Center. He also served in the U.S. military at Walter Reed Army Medical Center and completed a postdoctoral fellowship at the Royal College of Surgeons of England, obtaining a PhD in immunology from the University of London.

Dr. Katz is survived by his wife, Linda, and his children, Mark Katz, MD, Academy member Kenneth A. Katz, MD, MSc, MSCE, and Karen Katz.

Academy election opens March 2

View candidate materials on the AAD Election Connection
On Feb. 8 visit the AAD Election Connection at www.aad.org/aadelection to view candidates’ background materials including optional letters* and the ballot book.

Personalized Online Voting Link
Every week starting March 2 through March 16, eligible voting members will receive email notifications with a Personalized Online Voting Link. Click your personalized link to directly access the online voting site. Your personalized link will only be accessible via the weekly email notifications.

Alternatively, log in using your voting access code along with your AAD member ID# to access the Academy Election online voting site at www.esc-vote.com/aad2019. Election Services Corporation (ESC) will send access codes to all eligible voting members on Feb. 11 and March 2 via email or mail and weekly via email through March 16.

YOUR VOTE IS IMPORTANT

*The views and opinions in the candidate letters are their own and do not necessarily reflect those of the Academy or its policies.
**2019 Annual Meeting registration and housing are still available**

Register online to attend the Academy’s 2019 Annual Meeting in Washington, D.C., March 1-5 at [www.aad.org/AM19](http://www.aad.org/AM19).

Guest rooms are being held at several major hotels in Washington, D.C., at AAD discounted meeting rates. These rates are available only to those who book through the AAD. For a current listing of official AAD hotels, visit [www.aad.org/AM19](http://www.aad.org/AM19). Hotel reservations must be made online in conjunction with registration for the meeting. More information is available on the Academy website. **Please note: The AAD website is the only place where registration and housing arrangements may be made for the 2019 Annual Meeting, through the official vendor, Experient. When planning to register, ensure you are on the official Academy website.**

You can help expand the scope of vital community outreach programs and services by adding a donation as you register for the Annual Meeting. Be part of the Academy’s efforts to create a world without skin cancer by contributing to SPOT Skin Cancer™. This year, you can contribute to the AAD Graduate Member Resident Education Grant program. Help ensure that more than 1,300 dermatology residents are able to experience the meeting and build a bright future for the specialty. This program is applicable to AAD Graduate Members in AAD-approved U.S. and Canadian residency programs with a graduation year of 2019, 2020, and 2021. – **TIM MOSES**

**Academy seeks Honorary Member nominations**

**Nominations due by May 1**

The American Academy of Dermatology seeks nominations for individuals who have demonstrated leadership and service that affirms an uncommon and sustained dedication to dermatology and the goals of the Academy, a “lifetime” of dedication and distinguished service and although not a determining factor, nominees should have held a prominent office in the Academy. Criteria for a nomination is that the individual must be 65 years of age or older; or currently a Life member, or not otherwise eligible for AAD membership.

A nomination for Honorary Membership can be made by any member of the Academy at [www.aad.org/forms/honorarymembership](http://www.aad.org/forms/honorarymembership) by May 1, 2019. A brief biography of the nominee, including their accomplishments and rationale, is required, for the Board of Directors to consider when evaluating whether to grant honorary membership. The number of honorary membership recipients granted in a given year is limited to a maximum of five.

The Board of Directors will select Honorary Membership recipients at its July 2019 Board of Directors meeting. The recipients will be recognized during the Academy Annual Meeting, March 20-24, 2020, in Denver. For more information, visit [www.aad.org/forms/honorarymembership.](http://www.aad.org/forms/honorarymembership. – **CHRIS SIWIK**

**2019 AAD Election ballot packet moved online**

Beginning in 2019, eligible voting members will receive an email with an embedded link to view the ballot book and vote online. Voting members with email on file with the Academy will no longer receive an election ballot packet by mail. Paper ballots may be requested at candidates@aad.org.

- Members who wish to receive a PDF ballot book by email may request it at candidates@aad.org.
- Members who wish to vote by mail may print their online secure voting ballot beginning March 2.

**NOTE: All ballots must be received by March 16 at 11:59 PM (ET)**
AAD Annual Business Meeting agenda

The American Academy of Dermatology’s Annual Business Meeting will be held on March 3, 2019, in the Walter E. Washington Convention Center, Ballroom AB at 8 AM. It will follow the agenda below:

All members are strongly encouraged to attend.

8:00 AM
American Academy of Dermatology (AAD) Business Meeting
I. Call Assembly to Order
II. Establish Quorum
III. Introductions and Acknowledgements
IV. President-Elect Candidates’ Statements
V. Recognition of Industry
VI. Awards Acknowledgements
VII. Secretary-Treasurer’s Report
VIII. Unfinished Business
IX. New Business
X. Announcements
XI. Adjournment

American Academy of Dermatology Association (AADA) Business Meeting
I. Call Assembly to Order
II. Establish Quorum
III. Secretary-Treasurer’s Report
IV. Unfinished Business
V. New Business
VI. Recognition of Retiring Board Officers
VII. Adjournment

Informal Discussion of Issues of Importance from the Floor*

Pursuant to the Administrative Regulations of the American Academy of Dermatology and American Academy of Dermatology Association, during any debate at a membership meeting each speaker must introduce himself or herself by name and professional position. He or she must also identify any potential conflicts of interest.

*No CME Credit. dw
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Candidates should email their curriculum vitae with a letter of application to Professor Rod Sinclair at Rodney.sinclair@sinclairdermatology.com.au

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- Possibility of partnership
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AAD: Laying the foundation

BY EMILY MARGOSIAN, ASSISTANT EDITOR

2018 was quite the year, and over the past 12 months the Academy has continued to work hard for the dermatology specialty. Representing more than 20,000 physicians across the United States and abroad, the Academy has worked to meet the evolving needs of its diverse membership. You can continue to count on the Academy for support with everyday issues — with its practice management resources, CME opportunities, and quality reporting assistance — as well as big picture initiatives with the Academy’s advocacy and public education efforts. dw

Advocating for change - In 2018, 1,963 Academy members contacted policymakers through the Advocacy Action Center, and sent 3,620 letters to Congress, state legislatures, and federal agencies. At the 2018 AADA Legislative Conference, members participated in 240 meetings with members of Congress or their staff to discuss top-priority health care policy issues.

Skin in the news — Through the coordination efforts of the AAD’s communications team, there were 4,041 media stories featuring dermatologists online, on TV, on the radio, and in print.

Annual Meeting connections — The AAD’s 76th Annual Meeting in San Diego brought together 18,856 people, including 9,997 medical personnel.

Public education — More than 28 million web visitors accessed the AAD’s public education content on aad.org.

DataDerm™ makes MIPS easy — Currently in use in more than 1,000 active practices, more than 2,700 providers submitted with DataDerm for MIPS in 2017, reporting on almost 9,000 collective measures*.

Your favorite CME opportunity — Since its launch, almost 10,000 AAD members have put their knowledge to the test with the AAD’s popular ‘Question of the Week’ quizzes. In 2018, 8,073 members participated, earning a collective total of 211,877 CME credits.

Perfecting practice management — With more than one million visits to date, the AAD’s online Practice Management Center has become a go-to member resource. In 2018, 3,400 members used the PMC’s prior authorization letter generator to streamline the process of getting treatments approved for patients, and 1,500 members used the MIPS quality measures tool to help choose which measures to report.
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