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DWAD2018CA
Happy 2019!

Another year is upon us. The years seem to fly by these days — a hazard, I understand, of growing older. I suspect that many of you who are near my age (and you know who you are...) understand the sentiment! However, I certainly appreciate the privilege of enjoying another year. I welcome the opportunity the New Year offers to look back over the past year, revel a bit in what has been accomplished, and to set goals for the upcoming 12 months.

We will be doing this at Dermatology World, and we welcome your input, as we constantly strive to offer timely and useful information that benefits the many different facets of our membership.

Physicians have a lot on their plates these days, dealing with regulatory and administrative issues none of us ever imagined would be part of our careers. One of the questions I often hear in real and virtual gatherings of dermatologists is, “Why isn’t the Academy doing something about X?” Well, in many cases, the Academy is doing something. Hundreds of our colleagues are actively involved in AAD/A workgroups, taskforces, committees, and councils, working innumerable hours to enhance and protect our specialty. Even when I was an Academy Board member, I found it hard to keep track of everything that Academy members were doing. However, in some situations, the Academy cannot act, as jurisdiction of the issue lies beyond our organization’s purview. In our feature article, “Who you gonna call?” Dw Assistant Editor Emily Margosian explains which groups regulate the many different aspects of medicine that impact our profession. Medical licensure, board certification, maintenance of certification, scope of practice issues, nonphysician practitioner supervision, even payer issues are explored as she explains which body has regulatory authority over each. You may be surprised to realize who actually controls what.

This month, we also take a deep dive into the mysteries of one of my favorite topics: allergic contact dermatitis. Wherever you are in the patch testing scheme of things — whether you have just thought about doing patch testing, are a neophyte contact dermatitis detective, or are an accomplished patch testing guru — I promise you will enjoy, and learn something from, this delightful article. If you are just not into rashes, we share Dr. Susan Weinkle’s tips on improving your office efficiency, and address legal aspects for interacting with patients who do not speak English. And don’t miss Acta Eruditorum this month. You will come away with a whole new perspective. In our feature article, “Who you gonna call?” Dw Assistant Editor Emily Margosian explains which groups regulate the many different aspects of medicine that impact our profession. Medical licensure, board certification, maintenance of certification, scope of practice issues, nonphysician practitioner supervision, even payer issues are explored as she explains which body has regulatory authority over each. You may be surprised to realize who actually controls what.

In the spirit of looking back and looking forward, our final feature this month examines the progress made since DataDerm™, the Academy’s clinical data registry, rolled out in 2016. This extraordinary undertaking by the Academy has lived up to expectations and then some. To date, nearly 3,000 of our colleagues have submitted data on more than 20 million patient encounters. DataDerm has helped participants successfully report for MIPS, as well as benchmark their individual quality measures. Going forward, the Academy hopes to use the data collected to help improve access, to help define standards of care, and to ultimately show the value of the services we provide. We know what we do is valuable. DataDerm will help us show this in a meaningful and robust fashion to everyone else.

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

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FEATURES

30 TAKING THE WHEEL
Dermatologists discuss how DataDerm™ drives their success — and the specialty’s.

38 WHO YOU GONNA CALL?
Which groups regulate which parts of medicine?

44 ARE YOU A RASH WHISPERER?
Read more about allergic contact dermatitis.

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• 2018 ASHPE silver awards, Best Cover: Computer-Generated – February 2017
• 2017 ASHPE Gold award, Best Cover: Photo Take a pill – April 2016
• 2016 ASHPE Silver award, Best Cover: Photo Teledermatology – April 2015
• 2015 ASHPE Gold award, Best Cover: Photo Joining Up – July 2014
• 2018 AM&P Excel Silver Award, Website (Magazine)
• 2014 AM&P Excel Bronze Award, Design Excellence

DEPTS

01 FROM THE EDITOR
Physician Editor Kathryn Schwarzenberger, MD, previews this month’s issue.

06 WATER COOLER
This column features the thoughts of readers like you! This month we asked, “How ill do you need to be to take a sick day?”

08 NEW! ASKED AND ANSWERED
You asked, we answered: I am on the OLC. Where can I find the JAAD and Dialogues in Dermatology quizzes?

11 WHAT’S HOT?
Members of DW’s Editorial Advisory Workgroup share exciting news from across the specialty.

14 CRACKING THE CODE
Alex Miller, MD, discusses the new biopsy codes for 2019.

18 ADVOCACY NEWS
Tracking legislation and regulations at the state and federal levels.

22 ACTA ERUDITORUM
What is the role of commensal bacteria in triggering autoimmunity in lupus?

24 LEGALLY SPEAKING
Are you required to provide translation services for non-English-speaking patients?

28 ANSWERS IN PRACTICE
Find out how reliable staff and the right technology can improve practice efficiency.

50 FROM THE PRESIDENT
Academy President Suzanne Olbricht, MD, discusses the specialty’s 2019 advocacy challenges and opportunities.

52 FROM THE VICE PRESIDENT
Academy Vice President Theodore Rosen, MD, discusses the value of unity in the specialty.

54 NEW! IN YOUR CORNER
Find out what the Academy is doing to ease the administrative burden on physicians.

56 ACADEMY UPDATE
The 2019 AAD Election ballot packet has moved online.

59 CLASSIFIEDS

60 FACTS AT YOUR FINGERTIPS
Medical vs. cosmetic dermatology: Who is doing what? Flip to the back to find out.
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How ill do you need to be to take a sick day?

“What’s a sick day?”
— Nancy Samolitis, MD, West Hollywood, Calif.

“Vomiting non-stop or unable to walk. There have only been two times I’ve cancelled in 12 years!”
— Janelle Vega, MD, Miami

“A fever over 103.”

“Only if I physically can’t get out of bed or off the toilet.”
— Michael Lee, MD, San Diego

“A fever over 101 or vomiting that fails to respond to Zofran.”
— Laura Stitle, MD, Greenwood, Ind.

“Too many patients are relying on me every day, and I have nowhere to reschedule them!”
— Sara Moghaddam, MD, Selbyville, Del.

“I have only ever left the office and canceled patients one time in 12 years, and it was last month...for a kidney stone that required emergency surgery. I think it was justified.”
— Corey Hartman, MD, Chelsea, Ala.

“Mandatory bed rest from my Ob-gyn...almost passed out at work from dehydration and working too much! Was seven months pregnant and waddling.”
— Stacy Chimento, MD, Bay Harbor Islands, Fla.

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• To further refine your search, click one of the “Status” filters or one of the “Sort by” filters.
• Click a title for more information, or simply click the teal “Launch” button to begin the quiz in a pop-up window. (Make sure pop-ups are enabled on your browser.)
• If applicable, scroll to click “I accept, Continue Quiz,” or simply click “Begin.”

To access Dialogues in Dermatology quizzes:

• Click the “Dialogues in Dermatology” tab shown in the menu above. A list of available Dialogues in Dermatology quizzes will appear below.
• To further refine your search, click one of the “Status” filters or one of the “Sort By” filters.
• If you’re a subscriber, click “Launch.” If not, click the “Add to Cart” button to purchase the podcast and access the accompanying quiz.

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!
ILUMYA™ (tildrakizumab-asmn) is an interleukin-23 antagonist indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

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CONTRAINDICATIONS
ILUMYA is contraindicated in patients with a previous serious hypersensitivity reaction to tildrakizumab or to any of the excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity
Cases of angioedema and urticaria occurred in ILUMYA-treated subjects in clinical trials. If a serious allergic reaction occurs, discontinue ILUMYA immediately and initiate appropriate therapy.

Infections
ILUMYA may increase the risk of infection. Treatment with ILUMYA should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated.

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Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with ILUMYA. Do not administer ILUMYA to patients with active TB infection. Initiate treatment of latent TB prior to administering ILUMYA. Consider anti-TB therapy prior to initiation of ILUMYA in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Patients receiving ILUMYA should be monitored closely for signs and symptoms of active TB during and after treatment.

Immunizations
Prior to initiating therapy with ILUMYA, consider completion of all age-appropriate immunizations according to current immunization guidelines. Patients treated with ILUMYA should not receive live vaccines.

Adverse Reactions
The most common (≥1%) adverse reactions associated with ILUMYA treatment that were more frequent than in the placebo group are upper respiratory infections, injection-site reactions, and diarrhea.

Please see brief summary of Full Prescribing Information on next page or visit ILUMYAPRO.com for Full Prescribing Information.

Table 1 summarizes the adverse reactions that occurred at a rate of at least 1% and at a higher rate in the ILUMYA group than in the placebo group. In the placebo-controlled period of Trials 1, 2, and 3, adverse reactions occurred at rates less than 1% but greater than 0.1% in the ILUMYA group and at a higher rate in the placebo group. In a pre- and postnatal developmental study, subcutaneous doses up to 100 mg/kg tildrakizumab were administered subcutaneously during organogenesis to near parturition at doses up to 159 times the maximum recommended human dose (MRHD). When dosing was continued until parturition, a small increase in neonatal death was observed at 59 times the MRHD (see Data). The clinical significance of this nonclinical finding is unknown. No pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively. In a pre- and postnatal developmental study, subcutaneous doses up to 300 mg/kg tildrakizumab were administered to pregnant cynomolgus monkeys once every two weeks during organogenesis to gestation day 118 (22 days from parturition). No fetal or neonatal toxicities were observed at doses up to 300 mg/kg (159 times the MRHD based on AUC comparison). Tildrakizumab crossed the placenta in monkeys. In a pre- and postnatal developmental study, subcutaneous doses up to 100 mg/kg tildrakizumab were administered to pregnant cynomolgus monkeys once every two weeks from gestation day 50 to parturition. Neonatal deaths occurred in the offspring of one control monkey, two monkeys at 10 mg/kg dose (6 times the MRHD based on AUC comparison), and four monkeys at 100 mg/kg dose (59 times the MRHD based on AUC comparison). The clinical significance of these nonclinical findings is unknown. No tildrakizumab-related adverse effects were noted in the remaining infants from birth through 6 months of age. There are no data on the presence of tildrakizumab in human milk, the effects on the breastfed infant, or the effects on milk production. Human IgG is known to be present in human milk. Tildrakizumab was detected in the milk of monkeys. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for ILUMYA and any potential adverse effects on the breastfed child. In women who are or may become pregnant, ILUMYA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Protect patients from inadvertent intravenous injection. Medication Guide. Advise patients to seek immediate medical attention if they experience any symptoms of serious hypersensitivity reactions (see Warnings and Precautions). In the event of overdosage, monitor the patient for any signs or symptoms of adverse reactions and administer appropriate symptomatic treatment immediately.

**Table 1: Adverse Reactions Occurring in ≥1% of Subjects in the ILUMYA Group**

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>ILUMYA 100 mg (N=705)</th>
<th>Placebo (N=355)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper respiratory infections</td>
<td>98 (14)</td>
<td>41 (12)</td>
</tr>
<tr>
<td>Injection site reactions</td>
<td>24 (3)</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>13 (2)</td>
<td>5 (1)</td>
</tr>
</tbody>
</table>

* Upper respiratory infections include nasopharyngitis, upper respiratory tract infection, viral upper respiratory tract infection, and pharyngitis.

In clinical trials of another drug and may not reflect the rates observed in practice. Because clinical trials are conducted under widely varying conditions, adverse reaction rates in clinical trials cannot be compared to rates in the general population. No data are available on the response to live vaccines in patients treated with ILUMYA. No data on the presence of tildrakizumab in human milk, the effects on the breastfed infant, or the effects on milk production. Limited available data with ILUMYA use in pregnant women are insufficient to inform a drug associated risk of adverse developmental outcomes. Human IgG is known to cross the placental barrier; therefore, ILUMYA may be transferred from the mother to the fetus. An embryo-fetal developmental study conducted with tildrakizumab in pregnant monkeys revealed no treatment-related effects to the developing fetus when tildrakizumab was administered subcutaneously during organogenesis to near parturition at doses up to 159 times the maximum recommended human dose (MRHD). When dosing was continued until parturition, a small increase in neonatal death was observed at 59 times the MRHD (see Data). The clinical significance of this nonclinical finding is unknown. No pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively. In a pre- and postnatal developmental study, subcutaneous doses up to 100 mg/kg tildrakizumab were administered to pregnant cynomolgus monkeys once every two weeks from gestation day 50 to parturition. Neonatal deaths occurred in the offspring of one control monkey, two monkeys at 10 mg/kg dose (6 times the MRHD based on AUC comparison), and four monkeys at 100 mg/kg dose (59 times the MRHD based on AUC comparison). The clinical significance of these nonclinical findings is unknown. No tildrakizumab-related adverse effects were noted in the remaining infants from birth through 6 months of age. There are no data on the presence of tildrakizumab in human milk, the effects on the breastfed infant, or the effects on milk production. Human IgG is known to cross the placental barrier; therefore, ILUMYA may be transferred from the mother to the fetus. An embryo-fetal developmental study conducted with tildrakizumab in pregnant monkeys revealed no treatment-related effects to the developing fetus when tildrakizumab was administered subcutaneously during organogenesis to near parturition at doses up to 159 times the maximum recommended human dose (MRHD). When dosing was continued until parturition, a small increase in neonatal death was observed at 59 times the MRHD (see Data). The clinical significance of this nonclinical finding is unknown. No pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.
What’s hot?

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

Mallory Abate, MD

Many dermatologists still check baseline labs prior to prescribing oral terbinafine or griseofulvin for adults and children with dermatophyte infections, and then check again at a later point or periodically throughout therapy. However, results from a recent large retrospective study in *JAMA Dermatology* demonstrate that CBC and LFT lab monitoring for terbinafine and griseofulvin is unnecessary in adults and children without underlying hepatic or hematologic disease (doi:10.1001/jamadermatol.2018.3578).

In this study, which included laboratory data from 4,985 patients, the rates of AST/ALT elevations, anemia, lymphopenia, and neutropenia were low and equal to the baseline rates of abnormalities in the adult and pediatric populations. By forgoing unnecessary lab monitoring for these frequently prescribed medications, we can significantly decrease health care spending. As an example, according to the Centers for Medicare and Medicaid Services, the cost of a single ALT or AST test ranges from $7.20 to $7.40. A serum LFT panel costing $54.91 is often ordered with an additional venipuncture cost of $18.82. When applied to this study, the latter panel equals up to $325,296.76 in unnecessary LFT monitoring.

Rosalie Elenitsas, MD

Endocrine mucin producing sweat gland carcinoma. Are you familiar with this diagnosis? This neoplasm is a low-grade adnexal tumor that usually presents on or near the eyelid in elderly patients. It exhibits histopathological features similar to those seen in solid papillary carcinoma of the breast. Immunohistochemically, these tumors express epithelial markers (keratins) as well as neuroendocrine markers (chromogranin, synaptophysin, neuron specific enolase, CD56), but not CK20. Early tumors may be bland in appearance and easily misdiagnosed by pathologists, especially if mucin production is subtle. There is debate in the literature if the tumor represents a precursor to mucinous eccrine carcinoma, a lesion that is indistinguishable from metastatic mucinous carcinoma from the breast or gastrointestinal tract. In a recent issue of the *Journal of Cutaneous Pathology*, there are two articles on this topic. One article supports this stepwise progression utilizing array comparative genomic hybridization and BRAF pyrosequencing (2018; 45(9): 681-687), and in contrast, a second article suggests the two entities may not be related based on MYC expression (2018; 45(9):674-680). While more investigate work is needed on this topic, dermatologists should be familiar with this diagnosis.
Pyoderma gangrenosum (PG) is not a diagnosis of exclusion. Through a Delphi consensus exercise, Maverakis et al (JAMA Dermatol. 2018; 154(4): 461–466) came up with one major criterion and eight minor criteria to diagnose PG. The histopathology is the one major criterion — a biopsy from the ulcer edge MUST show neutrophilic infiltrates. Histopathology stains and tissue cultures are not required to exclude the diagnosis of PG, since superinfection is possible. Exclusion of infection is best done through histopathology. If the one major criterion is not fulfilled, all the minor criteria do not count. The eight minor criteria are: (1) exclusion of infection, (2) pathergy, (3) history of inflammatory bowel disease or inflammatory arthritis, (4) history of papule, vesicle, or pustule ulcerating within four days, (5) peripheral erythema, undermining border, tenderness at ulcer site, (6) multiple ulcers, at least one on anterior lower leg, (7) cribiform or wrinkled paper scars at site of healed ulcer, and (8) decreased size of ulcer within one month of initiating immunosuppressive medication. To have the highest yield on histopathology, the biopsy should be taken during a flare before immunosuppressive medications are initiated.

A Rocky lesson.

It was his very first day of residency, the doctor recalled (N Engl J Med. 2018 Oct 4;379(14):1299-1301. doi: 10.1056/NEJMp1806388), and he couldn’t answer his attending’s question during morning rounds. The newly minted doctor had, in fact, adequately presented the clinical details of a patient admitted for chest pain while walking his dog, but the resident had come up short when the attending asked, “What was the name of the dog?”

“I was stumped,” the doctor wrote. “Worse, I didn’t know why we needed to know. Nowhere in the books or the studies I’d read had a dog’s name contributed to the differential. But the attending took us back to the patient’s bedside and asked. ‘Rocky,’ the patient said. And there followed a brief conversation that was more colorful than any other I’d had with a patient that day. It led to a transformation I did not fully appreciate at the time: there was an actual person behind that hospital-issued gown.”

It’s a wise lesson. The demands on doctors’ time are legion, from managing short appointments to mastering electronic health records, from documenting visits to dealing with prior authorizations. Those are critical tasks, of course, but they don’t necessarily help us find joy in the practice of medicine or stave off burnout. Knowing Rocky’s name, by contrast, just might.

Moving forward, I’ll try to remember to ask the name of the dog. And, when I know I have a real connection with a patient, I’ll even share the name of mine.

Feeling the burn

Check out strategies for mitigating physician burnout at www.aad.org/dw/monthly/2017/september/feeling-the-burn.
Dermatologists continue to be adversely impacted by drug shortages. The AADA is aware of the issue and is engaged with stakeholders, including manufacturers, suppliers, the U.S. Food and Drug Administration (FDA), and Congress to facilitate access to patient care. Many of these medications are sterile injectables including, but not limited to, lidocaine, lidocaine with epinephrine, sodium bicarbonate, and bacteriostatic saline.

**How has the AADA addressed the drug shortages?**

Recently, the FDA created a Drug Shortages Task Force to come up with long-term solutions to drug shortages. This announcement highlighted the issues with sterile injectables — namely the consolidation in industry and the need to produce large volumes to be profitable.

In October 2018, the Drug Shortages Task Force met with the AADA in a listening session with other medical specialties on the clinical and economic impact of drug shortages. The AADA shared the difficulties dermatologists are having getting access to sterile injectables.

The AADA also conducted a survey of the general membership to see how drug shortages are affecting patient access and dermatologists’ ability to treat patients. The AADA presented results of the survey and emphasized the impact of the drug shortages at a public hearing with the FDA in November.

The AADA is also working in collaboration with many other medical associations on an ongoing basis to emphasize the impact of local anesthetic shortages with FDA staff.

**What can you do?**

Physicians are encouraged to stay informed on all drug shortages that are reported to the FDA and plan accordingly. The AADA has a drug shortages website where you can write to your members of Congress about the issue, and get resources on how to handle current shortages: [www.aad.org/advocacy/drug-pricing-and-availability/drug-shortages](http://www.aad.org/advocacy/drug-pricing-and-availability/drug-shortages). The FDA and the American Society for Health-system Pharmacists also have websites with current shortage information available at [www.fda.gov/Drugs/DrugSafety/DrugShortages/default.htm](http://www.fda.gov/Drugs/DrugSafety/DrugShortages/default.htm) and [www.ashp.org/Drug-Shortages](http://www.ashp.org/Drug-Shortages).

The association between atopic dermatitis and allergic contact dermatitis has been difficult to prove in the past because several studies used different inclusion criteria and various strategies for performing patch testing of the patients. There has also been confusion over whether the patients had a current or past history of atopic dermatitis. In their recent article, “Allergic contact dermatitis to personal care products and topical medications in adults with atopic dermatitis,” in the December *JAAD*, Rastogi, et al sought to clarify the presence or absence of an association between atopic dermatitis and allergic contact dermatitis by attempting to control for the previously mentioned factors (doi: 10.1016/j.jaad.2018.07.017).

They reviewed 502 charts of patients who had undergone patch testing with at least the North American Contact Dermatitis Group standard series and found that overall there was no difference between the rates of positive patch test reactions between patients with either a current or past history of atopic dermatitis and patients with no history of AD. However, when they evaluated specific allergens they did find significant differences in the rates of positive patch test reactions to personal care product ingredients and topical antibiotics (bacitracin, fragrance mix II, lanolin, cinnamal, chlorhexidine, tixocortal, and budesonide) between patients that currently have atopic dermatitis versus those without.

Among patients with a past history of AD, they had significantly more reactions to cinnamal, cyanoacrylate, quarternium-15, and lanolin. More than 90% of these reactions were relevant for the patients with atopic dermatitis, reinforcing the idea that we should be considering allergic contact dermatitis as a potential exacerbating factor in atopic dermatitis patients with refractory disease. dw
Now that you are certain that the new skin biopsy codes are specified by technique for 2019, you may be wondering how combinations of biopsy techniques done on the same day should be reported. It is obvious that multiples of tangential biopsies, CPT 11102, are used with add-on code 11103, multiples of punch biopsy, 11104, are coded with 11105, and additional incisional biopsies, 11106, are reported with pertinent multiples of 11107.

What happens when more than one biopsy technique is done on a patient during a single service encounter? The CPT® indicates that only one primary code should be used regardless of whether two or three different biopsy techniques are used. Which code is primary to which? It’s actually conceptually simple: The bigger primary CPT® code number trumps the smaller ones.

Incisional biopsy (11106) > Punch biopsy (11104) > Tangential biopsy (11102)

Such a hierarchy indicates that when any combination of incisional, punch, and tangential biopsies is done, the incisional biopsy (11106) is the primary code and all others are reported with the add-on codes: 11105 for punch, 11103 for tangential. When a punch and tangential biopsy are done together, then the punch is coded with 11104 and the tangential with 11103.

Here are some examples:

**Single technique**
- Three tangential biopsies: 11102, 11103 x2
- Two incisional biopsies: 11106, 11107

**Two or more techniques**
- One incisional, one punch, one tangential: 11106, 11105, 11103
- Two punch, two tangential: 11104, 11105, 11103 x2

The biopsy coding hierarchy is fortunately conceptually rather obvious. How about National Correct Coding Initiative (NCCI) Column 1/Column 2 (Procedure to Procedure or PTP) edits for other commonly used dermatologic procedural codes paired with the biopsy codes?

NCCI PTP (Column 1/Column 2) edits indicate two crucial coding determinants:

1. When appropriate, one of two paired primary codes (two different procedures done during the same encounter) may be reported with the 59 modifier.
2. Which of the two paired codes should receive the 59 modifier?

The NCCI PTP code pairings retain their present, somewhat conceptually challenging, pairing characteristics. Substitute the new biopsy codes for the old 11100 biopsy code in the Column 1/Column 2 pairs and voila, you have it figured out!

The premalignant destruction (17000, 17004), malignant destruction (17260-17286), benign (11400-1446) and malignant (11660-11646) excision codes are primary to the biopsy codes. This means that whenever any biopsy technique is done along with these procedures, the biopsy primary code receives the modifier. Remember that add-on codes, including add-on biopsy codes, do not require a 59 modifier. Only the primary code, which appears in Column 2 of the NCCI PTP edits, qualifies for a 59 modifier. Table 1 offers examples of code pairings.
In addition to the PTP (Column 1/Column 2) edits, the NCCI publishes Medically Unlikely Edits (MUEs). These indicate how many units of a given code on the MUE list may, when medically indicated, be covered by your Medicare Administrative Contractor (MAC) for the same patient on a single date of service (DOS).

Like other CPT codes, the skin biopsy codes have received MUE edits. This means that for a given date of service, if the number of billed units of a given code exceeds the MUE, the excess will automatically be denied by Medicare. Such non-payments may be appealed successfully to a MAC via a redetermination if the medical record confirms that biopsy numbers in excess of the MUE were both medically reasonable and necessary and were performed. See the table on the next page.
A patient comes in with multiple suspected basal cell carcinomas. You biopsy three separate lesions located on the right cheek, left neck, and right arm using the tangential technique. You also biopsy a nasal lesion clinically suggestive of a deeply infiltrating basal cell carcinoma using the punch technique. You report the procedures as CPT 11104, 11103 x3, with ICD-10-CM code D48.5 – Neoplasm of uncertain behavior.

Answer: Correct. It is prudent in this case to report all four biopsies with ICD-10-CM diagnosis of D48.5, neoplasm of uncertain behavior, indicating the final diagnosis was of uncertain morphology at time of obtaining the tissue sample, hence the need for the biopsy which will help determine the final diagnosis.

You do an incisional biopsy of a suspected scalp lentigo maligna and destroy 10 actinic keratoses with liquid nitrogen spray. You submit CPT 11106 for the biopsy and 17000 and 17003 x9 for the actinic keratoses destruction.

Answer: Incorrect. According to the NCCI PTP table, 11106 biopsy requires a modifier. Report the procedures appropriately as: 17000, 17003 x9, 11106-59.

You have learned from the above example and are determined to do this right. You destroy eight actinic keratoses with liquid nitrogen and biopsy two separate clinically atypical nevi using the tangential technique. You submit CPT 17000, 17003 x7 for the freezing destruction, and 11102-59 and 11103-59 for the biopsies.
Answer: Incorrect. You! Why is that? The NCCI stipulates that add-on codes do not merit a 59 modifier. That is why you will not find biopsy and other add-on codes paired in Column 2 of the NCCI PTP (Column 1/Column 2) listing. Avoid appending the 59 modifier to add-on codes, including the biopsy add-on codes 11103, 11105, and 11107.

In this case, the claim would be reported as: 17000, 17003 x7 for the freezing destruction, and 11102-59 and 11103 for the biopsies.

Example 4

During the course of a Mohs surgery on the nose of a Medicare patient, you identify a probable basal cell carcinoma on the patient’s right cheek. You and the patient would like to avoid a separate visit for a biopsy. You perform a biopsy of the cheek lesion using the punch technique and submit CPT 17311, 17312 for two stages of Mohs surgery, and 11104-59 for the biopsy.

Answer: Correct. First, Medicare policy allows payment for same-day biopsy(s) of lesions unrelated to the Mohs surgically treated tumor. The patient record should stipulate the separate location of the lesion. What if you biopsy a lesion using the tangential technique immediately preoperatively to confirm qualification for Mohs surgery via a diagnostic frozen section in a patient lacking a preoperative biopsy? The good news is that Medicare allows coverage of both the biopsy and the diagnostic frozen section processing and reading. Appropriately report the preoperative biopsy as CPT 11102-59 and 88331-59 for the frozen section and reading.

Example 5

You perform three biopsies on three separate clinically deeply palpable tumors using the incisional technique and two biopsies of carcinomas atypical nevi on the right arm and back using the tangential technique. You submit CPT codes 11106, 11107 x2 for the incisional biopsies, and 11102-59, 11103 for the tangential biopsies.

Answer: Correct. Appropriate hierarchical coding of the biopsies was followed. The MUE table was consulted, and it was determined that the MUE for additional incisional biopsies is 2, so it was not exceeded. The MUE for additional tangential biopsies is 6, so nothing worrisome there. The MUE for the first biopsy is always one since a primary code (11102, 11104, 11106) may only be used once per encounter regardless of how many different types of biopsies are done. In this example, 11106 is the primary code.

However, if some of the lesions are located in the same anatomical ICD-10-CM code grouping, then the payer may adjudicate some of the biopsies as “duplicate.” Stipulate the distinct locations in the “notes” section and be prepared to appeal if inappropriate payment denial were to happen. dw
The 2018 midterm results for Congress may have received most of the airplay, but let’s not forget to consider the impact of elections at the state level, where many of the American Academy of Dermatology Association’s (AADA) top advocacy priorities are deliberated. There were 36 gubernatorial races on the ballot, more than 100 ballot measures, and numerous state chambers predicted to be up for grabs. Here’s how it all played out:

- Democrats now hold 23 governorships due to the gain of seven seats (Ill., Kan., Maine, Mich., Nev., N.M., Wis.)
- Six state chambers flipped from Republican to Democrat (Colorado Senate, Maine Senate, Minnesota House, New Hampshire House and Senate, and New York Senate).

These results will be crucial for the redistricting battles to come after the 2020 election. With regard to dermatology’s priorities, states will see a mixture of old and new issues in 2019.

Drug pricing and PBM transparency

In 2018, a multitude of states passed legislation to prohibit gag clauses that prevented pharmacists from disclosing to customers cash prices and lower-cost alternatives for their prescription drugs. In September, President Trump signed legislation that prohibits pharmacy benefit managers (PBMs) and private payers from including gag clauses under Medicare Part D, Medicare Advantage, group health plans, and individual market exchange plans.

Many states, such as Idaho, New York, and Pennsylvania, may address deeper transparency issues with PBMs. Some states may pioneer legislation to address the emerging issue of ‘accumulator adjustment programs’ that prohibit copay coupons from applying to a patient’s deductible or out-of-pocket maximum. Colorado addressed this issue in 2018 via a regulation that requires 25% of insurers’ plans to have a fixed copay and no drug deductible and prohibits plans from placing more than 50% of drugs on their highest tier.

Legislative concepts to rein in drug costs or shed light on their pricing will resurface. Bills requiring industry to comply with transparency measures and reporting or bills addressing the practice of drug “price gouging” may be seen in Colorado, Florida, Massachusetts, New Hampshire, New Jersey, Pennsylvania, and Wisconsin.

Utilization management

States will continue to seek legislation to place guardrails around utilization management tools. Legislation to prohibit mid-year changes to formularies is expected in Pennsylvania. Delaware, Florida, Georgia, Kansas, Maine, Massachusetts, North Carolina, Ohio, Oklahoma, Virginia, Washington, and Wisconsin are expected to introduce bills that would ensure step therapy protocols are based on evidence-based and peer-reviewed clinical review criteria and would establish a basic framework for when it is medically appropriate to exempt patients from step therapy. Prior authorization legislation may be considered in Florida, New Jersey, New York, Pennsylvania, and Virginia.

Indoor tanning and sunscreen access

Twenty states and four counties in Maryland prohibit minors under 18 from using indoor tanning devices.
Arizona, Connecticut, Indiana, Maryland, Michigan, Missouri, Mississippi, Montana, and Nebraska may consider bills restricting indoor tanning in 2019. Seventeen states now allow students to bring sunscreen to school without a doctor’s note, and bills are expected in Georgia, Missouri, Rhode Island, and Texas (camps only, as they already allow at schools) next year.

Scope of practice
States that will likely seek legislation allowing for nurse independent practice include Arkansas, California, Indiana, Kansas, Massachusetts, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, Pennsylvania, and Texas. States that may see legislation to expand the scope of physician assistants or alter their supervision requirements include California, Indiana, Montana, Oregon, Pennsylvania, South Carolina, and Washington. Pennsylvania and Washington may see legislation that seeks to expand the scope of other non-physician clinicians, including optometrists, naturopaths, and pharmacists. dw
AADA successfully advocates against modifier 25 payment reduction 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.

The advocacy arm of the Academy, the American Academy of Dermatology Association (AADA) provides a voice to dermatologists, ensuring that public policies address the ever-changing needs of practices and patient care. The AADA provides members with valuable resources and tools to adapt to the shifting health care landscape while contributing to policies that protect the quality of, and access to dermatologic care.

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.

**Medicare physician payment**

Every year, the AADA dissects the proposed and final Medicare Physician Fee Schedule and offers comments and recommendations to CMS on policy changes. As a result of the advocacy efforts of the AADA and its members, in its final Medicare Physician Fee Schedule, CMS:

- Backed away from a concerning proposal to make aggressive changes to payment associated with modifier 25.
- Delayed implementation of a proposal to collapse the E/M code set and establish a single blended rate for levels 2-4 to 2021.
Patient access to care and treatments

The AADA advocates against barriers that restrict patients’ access to care and treatments.

Recently, the AADA:

✓ Collected feedback from Academy members on the impact of drug shortages and shared the responses with the FDA in person at a November 27 public hearing and in its official comment letter.

✓ Joined the American College of Mohs Surgery, the American Medical Association, the American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery in an in-person meeting with representatives from the FDA, the United States Pharmacopeial Convention (USP), and the CDC to discuss the need for patient access to in-office preparations in dermatology, specifically buffered lidocaine.

Telemedicine

The AADA supports policies that protect patient safety while enabling dermatologists to appropriately use teledermatology services to meet the needs of communities and populations across the country.

In the 2019 final Medicare Physician Fee Schedule, the AADA supported CMS’s increased coverage of telehealth services. CMS announced that it will:

✓ Reimburse for GVChi — a virtual check-in with an existing patient.

✓ Reimburse for GRASi — evaluation of images submitted by the patient.

CMS also finalized values for new CPT codes for Interprofessional Internet Consultation (CPT codes 99451, 99452).
What role does commensal bacteria play in triggering autoimmunity in lupus?

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Teri Greiling, MD, PhD, about her recent Science Translational Medicine article, “Commensal orthologs of the human autoantigen Ro60 as triggers of autoimmunity in lupus.”

Dr. Schwarzenberger: You and your colleagues recently published a very provocative study looking at the role commensal bacteria may play in triggering autoimmunity in lupus. Since our readers may not routinely read Science Translational Medicine, could you summarize your study and your key findings for them here?

Dr. Greiling: This project stems from the simple idea that some proteins are highly evolutionarily conserved, such that they have a similar sequence and structure in both humans and bacteria. Thus, a normal immune system attack of a bacteria can generate a B- or T-cell response that cross-reacts with the human protein in genetically susceptible individuals who may have HLA types that are not as good at editing out self-reactive lymphocytes. In this study, we showed evidence that antibodies and T-cells from anti-Ro60-positive human lupus patients are able to respond to both human and commensal bacteria Ro60. Furthermore, a germ-free lupus mouse model colonized with a common Ro60-producing gut commensal (Bacteroides thetaiotaomicron) developed anti-Ro60 antibodies and T-cells and lupus nephritis. Thus, we believe that Ro60 produced by bacteria may play a role in initiating and sustaining autoinflammation in patients with lupus.

Dr. Schwarzenberger: Ro60 is a ring-shaped protein with an RNA binding partner called Y RNA. Together this ribonucleoprotein complex appears to bind misfolded RNA in the cell and target it for destruction, as a sort of trash collector. When the function of Ro60 is blocked, cells are more sensitive to ultraviolet radiation and other environmental stressors. In terms of systemic lupus erythematosus (SLE), Ro60 is the “primordial antigen” for many patients, meaning it may be the first autoantibody formed. Seminal publications from other groups have shown that Ro60 antibodies can be detected in the serum more than five years before lupus symptoms appear — earlier than any other antibody. Furthermore, injecting Ro60 alone into mice can trigger epitope spreading and generation of other common lupus autoantibodies including Ro52, La, Smith, and U1RNP. Ro60 is also important in the pathogenesis of Sjogren’s Syndrome, Subacute Cutaneous Lupus Erythematosus (SCLE), and Neonatal Lupus.

Importantly for this study, Ro60 is produced by common human commensal bacteria, which colonize the skin, mouth, GI tract, and even the urogenital epithelium. For example, we found that Propionibacterium propionicum Ro60 activated many human lupus T- and B-cells. P. propionicum shares a genus with P. acnes and appears to be found in the same sebaceous distribution on the skin. I find it striking that the cutaneous eruption of subacute cutaneous lupus erythematosus (SCLE) mimics the sebaceous distribution where P. propionicum thrives. Clearly SCLE worsens with sun exposure, but the eruption usually spreads beyond sun-exposed skin and Ro60 commensals may help drive that inflammation.

Have you joined the JAAD Journal Club?

Join the JAAD Journal Club on Facebook for discussions on the latest research. Join at www.facebook.com/groups/ JAADJournalClub.
Dr. Schwarzenberger: It seems that we all could have Ro60 ortholog-containing bacteria in our skin. Is there anything unique about the commensal bacteria in the patients who got lupus? Or is it patient genetics that influences who gets lupus? Seems like there may be a “chicken or egg” issue here.

Dr. Greiling: That’s a great point. We probably all have at least a few strains of Ro60-producing commensal bacteria that colonize our bodies, but they aren’t usually harmful. Genetics and other environmental factors are clearly at play. I picture a scenario in which an individual gets, say, a sunburn at the beach. The skin gets inflamed and a harmless skin commensal gets caught in the crossfire. Antibodies are formed that just happen to bind the Y RNA binding site on *P. propionicum* Ro60. That individual happens to also have an HLA-type that is poor at editing out autoreactive antibodies and the anti-bacterial Ro60 antibody propagates in circulation and starts to bind self-Ro60. The individual may still not have symptoms but the autoreactive Ro60 antibodies create a low level of inflammation that triggers epitope spreading with formation of additional autoreactive antibodies. It may be years after that initial sunburn, but eventually the individual has enough autoinflammation to trigger symptoms of lupus.

Dr. Schwarzenberger: Do your findings offer any potential new therapies for lupus or other autoimmune disorders? Or, perhaps, any preventive strategies?

Dr. Greiling: I hope that someday soon we will have enough knowledge to harness the microbiota to cure or prevent disease flares. There are multiple autoimmune mouse models, including lupus, in which treatment with broad-spectrum antibiotics ameliorates the disease. However, in mouse models of melanoma treated with immunotherapy, broad-spectrum antibiotics hasten tumor growth. Clearly a balance is needed and colonization with the “right” microbes is vital.

There is currently only a dozen or so bacteria approved by the FDA as probiotics, and most of these are in the *Lactobacillus* family so their utility in inflammatory diseases is limited. Exciting work using helpful *Staphylococcus* strains to reduce skin colonization by harmful *Staphylococcus aureus* was just published last year. The hope is that we can use microbes to out-compete each other rather than continue to rely solely on antibiotics.

Dr. Greiling serves as assistant professor of dermatology at Oregon Health & Science University’s School of Medicine. Her article appeared in *Science Translational Medicine*. doi: 10.1126/scitranslmed.aan2306.
Language assistance services for non-English-speaking patients

By Christina L. Krysinski, JD, and Robert M. Portman, JD

Every month, Dermatology World covers legal issues in “Legally Speaking.” This month’s authors are health care attorneys with Powers Pyles Sutter & Verville PC in Washington, D.C. Portman is also outside general counsel for the AAD and AADA.

The ability to communicate effectively with patients is essential to providing quality care. If English is not a patient’s primary language, you may need to provide interpretation services or translated written materials. This article covers your obligations to patients with limited English proficiency, as well as privacy and payment concerns for language assistance services.

Q Am I required to provide interpretation services?
A Yes, if you receive federal financial assistance (including Medicaid, CHIP, or Medicare Part A payments). Under Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act (ACA), recipients of federal financial assistance must take reasonable steps to make their services available to individuals with limited English proficiency. Recipients of federal financial assistance include health care providers participating in Medicaid or the Children’s Health Insurance Program (CHIP) and hospitals and nursing homes receiving payments under Medicare Part A.

KEY POINT: Receiving only Medicare Part B payments does not count as receiving federal financial assistance.

If you are a covered provider, you should use the following factors to determine what reasonable steps to take to ensure meaningful access to your services for individuals with limited English proficiency:

- How many of your patients have limited English proficiency and the proportion of these patients to your total patient population;
- How often you come into contact with patients with limited English proficiency;
- The nature and importance of the services that you provide; and
- Available resources and the cost of providing language assistance services.

Based on these factors, you must design their services to ensure that they are meaningfully accessible to individuals with limited English proficiency.

Certain providers may also be required by accrediting agencies or by state law to provide language assistance services. In addition, failure to provide language assistance services may be unethical under standards of medical ethics. A recent article from the American Medical Association Journal of Ethics specifically focuses on the ethical implications of failing to provide appropriate language assistance in dermatology; learn more at https://journals.ama-assn.org/article/clinicians-obligations-use-qualified-medical-interpreters-when-caring-patients-limited-english/2017-03.
Q Am I required to provide translated written materials?
A Yes, if you receive federal financial assistance (including Medicaid, CHIP, or Medicare Part A payments).

Under Title VI, “vital documents” may need to be translated into frequently encountered languages. Whether a document is vital depends on the importance of the service and the information provided, as well as the consequences to the patient of not receiving the information. The following are potentially vital documents: consent forms, complaint forms, intake forms, notices regarding eligibility for benefits or services, notices advising people of free language assistance, documents that must be provided by law (e.g., HIPAA notice of privacy practices), and applications to participate in a program or to receive benefits.

In addition, the ACA requires covered providers to provide non-discrimination notices and descriptions of the availability of free language assistance services in the top 15 non-English languages in their state. HHS has compiled a list of these languages for each state at www.hhs.gov/sites/default/files/resources-for-covered-entities-top-15-languages-list.pdf. HHS’s regulations also provide templates for these notices at Appendixes A and B to 42 C.F.R. Part 92.

Q Who can provide interpretation and translation services?

Interpreters and translators must be qualified to provide language services. You should exercise caution when a patient chooses a family member or friend as an interpreter.

In order to be a competent interpreter, an individual must be more than just bilingual. The ACA requires that interpreters and translators be “qualified.” Under HHS’s guidance, a qualified interpreter is one who is “able to interpret effectively, accurately, and impartially, both receptively and expressively, using any specialized vocabulary required by the circumstances.”

If you frequently serve patients who speak a particular language, hiring bilingual staff and interpreters may be the best option. Many providers also contract with in-person, telephone, or video conference interpreters, especially when there is not a regular need for a particular language or when there is a need for services in many different languages. Many community-based organizations provide interpretation services and you can enlist the services of qualified community volunteers.

All interpreters, whether employees, contractors, or volunteers, should be familiar with the subject matter of the conversation and competent in the skill of interpreting, as well as knowledgeable of confidentiality and conflict of interest issues.

Some patients may feel more comfortable having a family member or friend act as an interpreter. However, a patient cannot be required to use a family member or friend. Providers must
offer the patient the choice of interpretation services arranged for by the provider at no cost. There may also be situations where use of a family member or friend, especially a child, is inappropriate. For example, patients may be uncomfortable discussing confidential or potentially embarrassing information in the presence of their child or the child may not be old enough to accurately translate the medical information being presented to their parent. Family or friends may also have a conflict of interest that interferes with appropriate interpreting (for example, where there is domestic abuse). Providers should exercise caution when a patient chooses a child as an interpreter and should make their patients aware of possible problems, including competency and confidentiality.

Ultimately, you should respect a patient’s desire to use an interpreter of their own choosing. Where a patient voluntarily chooses to use their own interpreter, such as a family member or friend, it is a good idea to maintain a record of your offer of no-cost interpretation services and of the patient’s choice.

Q Do patients need to provide authorization in order for me to share their information with an interpreter?

A No. When a health care provider uses an interpreter to communicate with a patient, the patient’s authorization is usually not required.

HIPAA generally allows covered health care providers to use or disclose a patient’s protected health information (referred to as “PHI”) without obtaining a patient’s authorization for the purposes of treatment, payment, and health care operations. Providing language services will usually fall within a provider’s health care operations under HIPAA. As a result, you do not need a patient’s authorization to share their PHI with an interpreter when the interpreter is a member of your workforce (i.e., an employee or a volunteer) or when you contract with another entity (called a “business associate”) and have an appropriate business associate agreement in place that provides assurances about how the business associate will handle PHI and meet other requirements. If you contract with an outside company or community organization to provide interpretation and translation services, you should have a business associate agreement in place with that entity in order to comply with HIPAA.

HIPAA also permits a provider to disclose PHI to a patient’s family member or other person identified by the patient as their interpreter for a particular health care encounter. As with other disclosures to persons identified by a patient as involved in their care, you can obtain the patient’s agreement or use your professional judgment to reasonably infer that the patient does not object to the disclosure of PHI to the interpreter.

Q Can I charge for translation and interpretation services?

A Providers that receive federal financial assistance must provide free language assistance services. Section 1557 of the ACA requires that providers receiving federal financial assistance provide language assistance services free of charge. This means that you cannot charge a patient for necessary interpretation or translation services. In addition, state law may prohibit you from billing your patients for language assistance services. Telephone interpretation services or community-based organizations that organize qualified volunteer interpreters may be low-cost options for providing necessary language assistance services to your patients.

The Americans with Disabilities Act (ADA) of 1990 is a federal civil rights law that prohibits discrimination based on disability. The ADA includes regulations on providing certain auxiliary aids and services to ensure effective communication with patients with covered disabilities, such as hearing or sight impairments. However, the ADA does not consider lack of English proficiency to be a covered disability, and such regulations would therefore not apply to non-English-speaking patients who do not have an ADA-covered disability. For more information on ADA compliance, visit www.aad.org/dw/monthly/2017/may/is-your-dermatology-practice-ada-compliant.

The Hill 90D Dermatology Chair offers an impressive list of features compared to other models and with quality you’d expect from a fourth generation company. Electric height, power lift-back, manual adjustable foot section, adjustable headrest and up to 600 lb. lift capacity are all standard. Add options like electric tilt and foot sections, removable armrests, contour cushions and matching stool to make the 90D the perfect solution for your practice.

Starts at $4295
Running a tight ship

Best practices for office efficiency

BY VICTORIA HOUGHTON, MANAGING EDITOR

Dermatology World talks with Susan Weinkle, MD, from Bradenton, Florida, about how reliable staff and the right technology can improve practice efficiency.

DERMATOLOGY WORLD: Tell me about your practice.

Dr. Weinkle: I am in private practice and I’m a Mohs surgeon. I also do aesthetics — Botox, fillers, cryotherapy, and chemical peels — and I typically see about 120 patients a week. I have a nurse practitioner, who has been with me for 30 years, seven assistants, and a bookkeeper who comes in one day per week. I also do clinical trials on aesthetics. One of my assistants is a clinical study coordinator.

Q What do you do to ensure that you and your team are communicating consistently, and what are the important pieces of information that you make sure you communicate?

Dr. Weinkle: My mother years ago instigated a plan called “attitude adjustment” where we’d go out for an early dinner together. At my practice, we all go out to dinner together and have important bonding time. We talk about how important it is that the patients feel cared for. Everybody has to have the same philosophy: We care about the patient.

Also, about once a month we have a lunch together and discuss any challenges that have come up. For example, one big challenge is trying to stay on schedule. I — as a physician seeing a patient — can’t focus on my watch and what time it is. I have to rely on my office staff to give me feedback. For example, “Okay, Dr. Weinkle, you talked too long there and we’re now 30 minutes behind.” I recognize that I need their support to keep me on track. We talk about that when we go out to lunch and improvements that can be made to be more efficient. You have to bond as a team to ensure efficiency. It’s team building and I think that you have to have everyone on the same page.

Do you have a standard operating procedures manual for your administrative staff?

Dr. Weinkle: We just have an OSHA and HIPAA manual. My philosophy is that if one of my assistants needs help with something or has a problem, they know I’m there for them. I know of practices that have strict guidelines where everything is written in stone. They have high employee turnover. At my practice, employees stay forever. The longer your staff has been with you the more they know the job and the more likely things are to run like clockwork.

What steps have you taken to ensure efficient patient flow in your practice?

Dr. Weinkle: My office staff knows how to put the patients who are going to need numbing in a certain room or a patient who needs surgery in a different room, so the patient flow is pretty easy. We also have a light system in the office that tells me where to go and it lets the office staff know where I am. There’s a little panel of lights outside.
Effective patient communication can be the key to keeping things moving in the practice. What do you do to ensure that your patients feel heard and that they understand their condition, treatment, medications, etc.?

Dr. Weinkle: My assistants communicate with the patients before I come into the room to identify their concerns and their needs. I come in and do my part, and then my assistant spends time with that patient making sure they understood everything. We have printed instructions to hand to the patient if needed, because I have a more mature population. We have to make sure we communicate in written form.

What do you do personally to get ready for the day to ensure efficiency?

Dr. Weinkle: In the morning when I walk in, I say good morning to everyone and I take the pulse of the office. Saying good morning is communicating and connecting with your office staff. You have to get your team focused and on board.

What is the value of running an efficient office?

Dr. Weinkle: It’s more personally rewarding and less frustrating. You’re happier at the end of the day because you’re not stressed out, and patients are happier because they can pick up on that. Overall, I think the key is hiring and training people who are the extension of you. It’s what makes a practice efficient and rewarding. That’s the bottom line. I’ve been in practice 35 years and I love going to work.

Dr. Weinkle is a Mohs surgeon at her practice in Bradenton, Florida. She serves as an assistant clinical professor of dermatology at the University of South Florida.
TAKING the WHEEL

Dermatologists discuss how DataDerm™ drives their success — and the specialty’s
“As a small specialty, it may not come as a surprise when the valuable care we provide goes unnoticed,” said Henry W. Lim, MD, the Academy’s immediate past president in a From the President column. “Of course, we all understand the significance of the work that dermatology contributes to the health care world and so do our patients. However, there are policymakers, members of the public, and colleagues in other specialties who may not know what we do or the value that we add.”

Indeed, according to a study published in the European Academy of Dermatology and Venereology, 77% of 247 patients who received a medical consultation from a dermatologist were satisfied with their visit [doi.org/10.1111/jdv.13652]. While patient testimonials indicate a clear satisfaction with the specialty’s care, information about the uniqueness of dermatologists’ expertise often flies under the radar.”

By Victoria Houghton, Managing Editor
Fortunately, in 2016, the Academy launched DataDerm™ — a clinical data registry — to fill the knowledge gaps about the breadth and depth of the specialty’s care. “DataDerm is a treasure trove of information for anyone interested in improving how they provide patient care,” said George Hruza, MD, MBA, Academy president-elect. Additionally, “It’s incredibly valuable not just to physicians individually, but it can inform how dermatology is perceived.”

Experts and users discuss how DataDerm has helped improve their practices and the role it can play in improving patient care and refining the narrative about dermatology.

What is DataDerm?
DataDerm is a clinical data registry developed by dermatologists for dermatologists. To date, the platform has been utilized by nearly 3,000 physicians and other providers in 1,020 active practices, submitting data encompassing 21.6 million patient visits and 8.1 million unique patients.

Working with both electronic and paper record practices, the registry connects data on millions of patients from thousands of dermatologists nationwide, eases the pain of reporting for programs, such as the Merit-based Incentive Payment System (MIPS), and allows physicians to demonstrate the quality of care they provide to payers, policymakers, and the medical

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DataDerm users’ MIPS 2017 results

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community. The registry also offers participating physicians a private analysis of their practice’s data and compares it against national averages — down to the patient level.

“You have a dashboard, which tells you how you are doing in terms of the quality measures you want to report on — which of course is important to many of us,” said Dr. Hruza. “We also track other measures, which are not yet quality measures, but maybe will be one day and you can see how you are doing compared to other dermatologists.”

How is DataDerm being used in practice?

**MIPS reporting**

From increasing prior authorization requirements, to complex documentation standards, to heavy patient loads, it comes as no shock that the life of a physician is a busy one. Furthermore, a recent Mayo Clinic Proceedings study found that while overall physician burnout levels rose from 45% to 54% between 2011 and 2014, burnout among dermatologists during that same time frame rose from 32% to 57% (2015:90(12):1600-1613).

“Right now, many measures that we report have been developed by somebody else, and not a lot of them are dermatology-specific. We’re going to start using the information we collect to develop quality measures that are meaningful to dermatologists and their patients.”


Reporting requirements and their associated penalties have been identified as one of the many factors contributing to physician burnout. Indeed, the stakes are high: It is projected that the average dermatologist could lose about $200,000 in the next five years if they don’t report. Physicians can’t afford to not report, said Howard Rogers, MD, chair of the Academy’s Patient Access and Payer Relations Committee.

“In general, being part of a clinical data registry really helps dermatologists on an annual basis to fully participate with the government mandates associated with MIPS. I think it’s a no-lose situation.” Indeed, reporting via DataDerm was a no-lose situation for members in 2017 — as 2019 gets underway, no one who used DataDerm to report for MIPS will see a Medicare penalty, and many users will see a high-performance bonus (see graphic).

Mary Barber, MD, at the Skin Cancer Center of Central Florida, used DataDerm to successfully report for MIPS in 2017 — reporting nine measures and earning a 2.1% payment bonus. “I thought DataDerm did a great job,” said Scott Kelley, MBA, practice administrator for the Skin Cancer Center of Central Florida. “Getting set up was just a matter of getting a hold of FIGmd [the Academy’s registry vendor] and having them set up the configurations and map out all of the fields. They did several mapping meetings with us where we would go back and look at the data for missing fields. All in all, the process was very good and they were very friendly and nice people to work with. They did a great job.”

All told, Dr. Barber and Mr. Kelley would recommend DataDerm for MIPS reporting. “DataDerm puts the data in a nice, graphical user-interface that makes it easy to follow and easy to deal with when the submission period comes around. I would highly recommend it,” said Kelley. “Anything that makes my job easier is favorable. The less paperwork that I have to do, the better.”
For tools, resources, and training videos on how to report or document for MIPS manually or electronically, visit the DataDerm resource library at www.aad.org/dataderm/resource-library.

**Quality improvements**

In addition to easing the headaches associated with reporting, DataDerm has helped many take stock of the care that their practices provide. DataDerm currently provides individual benchmark reports on 27 dermatology-specific or applicable quality measures for all patients — not just Medicare — that allow physicians to drill down to the patient level, offering a complete profile of the care that they’re providing in their practice.

For Dr. Hruza, some of the quality measures from reporting programs of the past, such as PQRS, didn’t have any bearing on his practice. “For me, reporting how many of my patients have had the influenza vaccine has absolutely no relevance. But these dermatology-specific measures can be used to make meaningful improvements in your practice, and I would think the vast majority of dermatologists care about the quality of care they provide. DataDerm gives physicians the ability to see and focus on those areas where they can make improvements.”

How does this work in practice? Dr. Hruza — who has been using the registry for almost three years — says that his experiences with the quality tools in DataDerm have been eye-opening. As a surgeon, Dr. Hruza wanted to see how long it took for patients to be notified of biopsy results and how he compared to other dermatology surgeons. Using DataDerm, Dr. Hruza learned that it took more than a week for patients to be notified of results. “We figured out that the problem was getting lab results into the EHR in a timely manner and setting up a to-do list to flag incoming results for me to see. A few minor tweaks reduced our turnaround time of getting results to patients by 30%. To me, that made a difference, and DataDerm allowed me to follow our progress.”

Brent Moody, MD, chair of the Academy’s Resource-Based Relative Value Scale Committee, argues that DataDerm can help physicians see how they are faring against colleagues. “Being a nationwide database, it encompasses a large number of patients. By having those data points, it really allows a practicing dermatologist to understand if his or her practice pattern falls within the norm, or what their peers are doing. It will help people self-audit their practices.”

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“Data can help make sure that we’re recognized for the importance of the diseases that we treat.”

For Marta Van Beek, MD, MPH, the Academy’s assistant-secretary treasurer and co-chair of the Academy’s Ad Hoc Task Force on Data Collection Platform and Registries, DataDerm’s current quality improvement tools have only just scratched the surface. “Right now, many measures that we report have been developed by somebody else, and not a lot of them are dermatology-specific. We’re going to start using the information we collect to develop quality measures that are meaningful to dermatologists and their patients. We need measures for general dermatologists, pediatric dermatologists, surgical dermatologists, and dermatopathologists.”

For a list of MIPS and QCDR measures, visit www.aad.org/quality-measures.
How will data from DataDerm be used in the future?

With full integration with the medical record, DataDerm collects volumes of information beyond what is collected for MIPS reporting. Depending on the type of EHR and degree of integration, diagnoses, medications, disease manifestations, treatment plans, and utilization can be collected on patients. “Most of what we know about utilization has been taken from the Medicare population,” said Dr. Van Beek. “Using DataDerm, we can now measure Mohs surgery utilization in younger patients who have private insurance coverage. Thus far, the data indicates appropriate use of Mohs surgery and an average number of stages on par with the Medicare population.”

What’s even more exciting is that we can use some of this data to develop surgical-specific measures for quality reporting, allowing surgeons more choices in MIPS reporting.

Additionally, “We’ve looked at what kinds of medications have been prescribed for atopic dermatitis, psoriasis, acne, and actinic keratoses. We’ve looked at the proportion of patients who have been prescribed field therapy for actinic keratosis — an indicator for skin cancer prevention,” said Dr. Van Beek. Now that this information is starting to take shape, what’s next?

Improve patient access

Dr. Rogers argues that these data can offer a new narrative about dermatologic care and demonstrate the complexity of conditions that dermatologists treat for payers. “One of the biggest problems is that, unfortunately, insurers basically have one blunt tool in terms of looking at quality: Cost. How much does a physician cost on a per-member, per-month (PMPM) basis?” As a result, payers may institute policies — such as physician tiering — that attempt to cut costs but inevitably reduce access to care to physicians who treat complex conditions. Since many dermatologists treat diseases that have widely varying severity, this is a problem.

“The most obvious example would be skin cancer, which ranges from small, easily treated lesions to a life-threatening cancer,” said Dr. Moody. “With psoriasis you may have very limited disease that can be easily treated with generic topical medicines, or you can have widespread disease refractory to topical medicine that requires a biologic. Currently, there is no way for a payer or anyone else by looking at claims data to know what disease you’re actually treating — how severe it is.”

“One of the most important things that we need to do is move things away from that PMPM basis to more of a risk-stratified, outcome-based measurement of how physicians work,” said Dr. Rogers. Going forward, Dr. Rogers is hopeful that the data will be useful in arguing for payer policies that improve access to care. “I think that’s one of the ways that we’re going to be able to use the data. We’ll be able to meet with insurers and say, ‘Our dermatologists dealt with one million people with psoriasis and it wasn’t just regular run-of-the-mill psoriasis. It was psoriasis that was head to toe and that’s why these patients needed biologics. Even though it seems like the dermatologist might be expensive, they’re treating patients in an appropriate manner that follows clinical guidelines and is appropriate.’”

“Private payers are eager to implement quality metrics,” said Dr. Van Beek. “It would be far better for the dermatology specialty to define those quality metrics than for an insurance company to define quality for us. As dermatologists, we know cost is not a surrogate for quality. Patients with more severe inflammatory disease or patients with more complex malignancies require a higher (and costlier) level of care. With DataDerm, our specialty can define quality, develop measures that are meaningful to patients, and offer them as an option for AAD members to use to

“If dermatologists don’t participate in a meaningful collection of real-world data, then other entities, government and insurance providers, for example, will set for us unsubstantiated and invalidated standards of care.”
prove their value to insurance companies with which they may contract.” Additionally, said Dr. Moody, these data can help ensure that dermatologists receive fair reimbursement for the care they’re providing. “Data can help make sure that we’re recognized for the importance of the diseases that we treat, the impact our care has on the quality of life of our patients, and in some instances — particularly with malignant conditions — the impact we have on their mortality. I think we all want fair reimbursement.”

However, in order to make measures and MIPS meaningful, everyone needs to lend a hand, advised Dr. Rogers. “Having the vast majority of dermatologists putting data in DataDerm increases the value of what we can offer insurers for potential access to performance measures or different risk stratification. If only 5% of our members contribute data, negotiating with DataDerm is less attractive to insurers. However, in an ideal world, the AAD would be able to say that most of our members participate in the registry, and we’d like to work with insurers to ensure measures of cost and performance are relevant and fully risk stratified. That would be very valuable to our interactions in advocacy with payers.”

Theodore Rosen, MD, the Academy’s vice president, agrees. “Massive nationwide data, when collected carefully so as to be truly representative of real-world practice, provides an opportunity to determine and help set realistic and optimum therapeutic standards of care. While a large number of dermatologists are participating in DataDerm, many more are needed.”

**Define specialty value and standards of care**

Why is it critical to join DataDerm now? “DataDerm will prove our value,” said Dr. Van Beek. “Frequently, insurance companies require a higher co-pay to see a specialist compared to a primary care provider. If we can prove our efficiency in getting patients better more quickly, with the correct diagnosis and treatment, that has potential to show value for the specialty. If a dermatologist can diagnose a patient with a skin disease and get them better within one or two visits, that’s more efficient than seeing their primary care physician six times and not receiving an accurate diagnosis or getting the proper treatment. In that case, a cheaper co-pay to see a dermatologist sooner, would be more cost effective for the insurance company.”

Dr. Moody indicates that data from DataDerm will be able demonstrate that dermatologists are uniquely qualified to diagnose and treat a number of complex diseases in a more efficient way than other physicians and providers treating skin conditions. “We can do it in fewer visits and with more precise therapy than anyone else. Having a good, robust data set will let us show that one visit to the dermatologist is more likely to solve the problem, than perhaps multiple visits to a non-dermatologist.”

In order to tell an accurate story about the specialty, dermatologists need to write the book, said Dr. Rosen. “If dermatologists don’t participate in a meaningful collection of real-world data, then other entities, government and insurance providers, for example, will set for us unsubstantiated and invalidated standards of care. The larger the cohort of participants, the more robust and accurate a picture can be ascertained regarding current intervention trends and outcomes.”

“Private payers are eager to implement quality metrics. It would be far better for the dermatology specialty to define those quality metrics than for an insurance company to define quality for us.”

To learn more about DataDerm, visit [www.aad.org/dataderm](http://www.aad.org/dataderm).
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Made by dermatologists for dermatologists.
“WHO YOU GONNA CALL?”

Which groups regulate which parts of medicine?
Health care policy is notoriously complex, and even physicians with years of experience may not be completely clear on who writes the rules. While democracy still dictates that legislators sit at the top of the regulatory hierarchy, firing off an impassioned email (or tweet) to your state senator is unlikely to inspire immediate action. Beyond Congress, a myriad of state and national boards manage key areas of practice — but which one should dermatologists contact with concerns about licensing or CME requirements? Who is responsible when the local naturopath claims dermatologic training on their website? What course of action is available when your patients are faced with onerous step-therapy requirements? Should you be sending your opinions on MOC to the president of the AAD? If you’ve asked yourself these questions, before you send that next angry tweet, consider *Dermatology World’s* regulatory roadmap to:

- The basics: Licensure, CME, medical scope and supervision
- Maintenance of certification
- Scope and truth-in-advertising for non-medical providers
- Payer issues >>

BY EMILY MARGOSIAN, ASSISTANT EDITOR
The basics of being a physician:
Who regulates?

Much like recreational marijuana and the minimum marriage age, laws dictating the practice of medicine are mostly a state-run affair. “Each state has a medical practice act, which is enacted by that state’s legislature,” explained Lisa Albany, JD, AADA director of state policy. “These statutes are really geared toward protecting the public from unprofessional conduct and incompetent acts that might occur in the practice of medicine.”

It is through these key pieces of legislation that state medical boards derive their authority — a mini-medical Constitution of sorts. “The state-created medical practice acts grant medical boards the oversight and authority to regulate physicians. The medical boards develop rules on licensure, continuing medical education, discipline, and will also handle policy or guidelines on particular issues, for example office-based surgery, or pain management,” said Albany. The boards themselves are typically comprised of a mix of members of the public and physicians from different specialties — dermatology included. “Seats are typically appointed by the governor, and we are fortunate to have dermatologists on several states’ medical boards,” said Albany.

While physicians clearly fall under the purview of state medical boards, what about the regulation of non-physician medical providers such as nurse practitioners (NPs) or physician assistants (PAs)? “The board of physicians regulates MDs, the board of nursing regulates nurses,” said Larry Green, MD, chair of the AAD State Policy Committee. “Physician assistants are often under the auspices of the board of physicians as well, as they’re considered physician extenders.” However, this can prove to be a gray area in a few states where physician assistants have established their own independent boards. “Where you generally run into issues is when physicians think that a PA board or a nursing board is trying to expand their scope into the practice of medicine — then you have to see how the legislature has defined it in the statutes,” said Albany. “Sometimes it’s just unclear, and then you may have regulations being challenged in court.”

If physicians observe scope of practice issues involving a medical provider, Albany recommends first contacting the board that directly regulates the potential offender. “If a physician believes that a nurse is doing something that falls within the practice of medicine, they could go to the medical board,” she said. “However, we would recommend that physicians contact the nursing board first, because the nurse in question is ultimately a licensee of that board. You’d do the same thing for physician assistants. If they’re being regulated by a PA board, then you’d want to go to them. If they’re being regulated by a medical board, then you can go straight to the state medical board to report.” It should be noted, said Albany, that if there’s a violation of the medical practice act, an individual could contact the medical board with concerns that an unlicensed individual is practicing medicine. Medical boards may have the authority to issue cease and desist orders and/or obtain an injunction to restrain a person from violating any provision of the state medical practice act.

If a physician feels action is needed that requires a change to state law, they can look to the AADA for assistance engaging with state legislators. “A change in scope of practice rules often involves amending the statutes, and that’s a legislative process,” explained Albany. “This is an area where we would be engaged with lobbying our state legislators to introduce a bill to remedy the issue.”

Do you have scope of practice or truth-in-advertising concerns that you would like the Academy to help address? If so, complete the AADA’s brief form at www.aad.org/advocacy/scope-of-practice/tia-sop-intake-form.
**MOC: Who’s in charge?**

While maintenance of certification (MOC) remains a hot-button issue for many dermatologists, there is often much confusion regarding which organization actually manages and regulates the process.

**ABMS**
The American Board of Medical Specialties (ABMS) determines MOC requirements for its member boards.

**ABD**
The American Board of Dermatology manages and implements the MOC process based on ABMS requirements.

**MOC**

At the very top of the MOC hierarchy is the American Board of Medical Specialties (ABMS). The ABMS sets maintenance of certification requirements for each of its member boards — whose ranks include the American Board of Dermatology (ABD). In order to maintain recognition by ABMS, the ABD must then adopt these recommendations into dermatology’s MOC requirements. Currently, dermatologists completing MOC must meet three components, which include:

1. Licensure and professional standing
2. Lifelong learning and self-assessment
3. Cognitive expertise

For more information on each component, visit [www.aad.org/education/moc](http://www.aad.org/education/moc).

To alleviate confusion regarding the role of the ABD vs. the AAD in MOC, Arthur Joel Sober, MD, chair of the AAD’s Council on Education, clarified, “The criteria for certification and re-certification fall to the ABD. The AAD, as one of its functions, tries to help its members meet those requirements, but we don’t establish them.” So what support can members expect from the Academy regarding MOC? Overall, the AAD’s primary role is as a provider of educational support. Dermatologists can look to the Academy for CME opportunities, online modules, and the popular Derm Exam Prep Course to help meet their MOC requirements. “A lot of what the Academy committees are set up to do is evaluate and respond to the leadership of the ABD,” said Dr. Sober. “Once the board has set what it is that’s required, then the AAD tries to create or adapt programs to fit those requirements.”

For a full list of activities and resources offered by the AAD to help fulfill MOC requirements, see the chart below.

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<thead>
<tr>
<th>Activity</th>
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<td>JAAD quizzes (Free)</td>
<td>Component 2</td>
<td>Available at <a href="http://olc.aad.org/diweb/catalog?q=JAAD">olc.aad.org/diweb/catalog?q=JAAD</a></td>
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<td>Question of the Week (Free)</td>
<td>Component 2</td>
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<td>Case Challenges Self-Assessment (Free)</td>
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<td>Patient Safety in Dermatology</td>
<td>Component 2</td>
<td>Available at <a href="http://store.aad.org/products/10446">store.aad.org/products/10446</a></td>
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<td>Hands-on Cosmetics course</td>
<td>Component 2</td>
<td>Available at <a href="http://www.aad.org/meetings/hands-on-cosmetics">www.aad.org/meetings/hands-on-cosmetics</a></td>
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<td>Derm Exam Prep Course</td>
<td>Component 2 and 3</td>
<td>Available at <a href="http://www.aad.org/meetings/derm-exam-prep-course">www.aad.org/meetings/derm-exam-prep-course</a></td>
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<tr>
<td>Dermatology Self-Assessment Program – Pediatric and General</td>
<td>Component 2</td>
<td>Available at <a href="http://store.aad.org/products/10146">store.aad.org/products/10146</a></td>
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<tr>
<td>Many Annual and Summer Meeting sessions</td>
<td>Component 2</td>
<td>For more information, visit <a href="http://www.aad.org/meetings">www.aad.org/meetings</a> and look for the “MOC” icon in program.</td>
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**Non-medical scope and truth-in-advertising: How to fight back**

As with medical scope of practice, non-medical providers (naturopaths, dentists, optometrists, aestheticians, etc.) are subject to the rules of their own boards, which are bound by laws created by state legislatures. “Again, you’d want to start with the licensee’s board if you’re concerned that they’re acting outside their scope of practice,” said Albany, who cautions that dermatologists do their homework before submitting a complaint. “Each state has a different process in terms of investigation. You should also be aware of what your state’s policy is on submitting anonymously; some states require the name of the person making the complaint.”
Complicating matters are the potentially competing interests of the boards themselves. “If the medical board determines that botulinum toxin falls within the practice of medicine, and a dentist or naturopath administers botulinum toxin — then they’re practicing medicine without a license,” said Dr. Green. “However, it can get tricky if the board of naturopathy counters and says, ‘no, botulinum toxin is part of the practice of naturopathy.’ Ultimately, it’s up to the legislators to decide.”

Dr. Green agrees, adding, “The AADA needs members’ help to bring this to our attention, and then we’re able to provide them and their state society with information on that state’s exact laws and regulations on whether or not this person is indeed committing a violation. The AADA does not do a search and destroy for everyone who is violating scope of practice. We can go after new regulations, new legislation in your state, but we cannot go after someone directly — that’s where the restraint of trade comes in.”

Despite these limitations, the AADA has clocked some powerful wins over the last 12 years as part of the AMA Scope of Practice Partnership (SOPP) steering committee, which awards grants to state medical societies and national specialty societies for scope of practice initiatives. “Since 2006, SOPP has awarded $1.6 million, and in 2013 alone, 600 scope of practice bills were introduced nationwide, with only one resulting in nurse practitioner independent practice,” said Albany.

Dr. Green recommends dermatologists with scope of practice concerns lean into the unique power of their state societies. “We can assist, but the AADA cannot work in a state independently without the help of the state medical or state dermatologist society, because they have the influence on state legislators,” he said. “We are there to provide resources whenever they need our help. If you notice something going on in your state that you think is not safe for patients — unqualified people doing medical procedures that they shouldn’t be doing, or someone claiming to be a dermatologist and they’re not — you should contact your state dermatology society, and then get in touch with the AADA State Policy Committee. You tell us your issue, and then we can go from there.”

**State Advocacy Grants**

Every year, 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. Learn more at [www.aad.org/StateAdvocacyGrant](http://www.aad.org/StateAdvocacyGrant).

Have you witnessed false or misleading material from a provider claiming to be a dermatologist? Visit the AADA’s Scope of Practice Action Center for pathways to action at [www.aad.org/advocacy/scope-of-practice/action-center](http://www.aad.org/advocacy/scope-of-practice/action-center).

What can the AADA do to help? “We partner with state dermatology societies to enact laws concerning truth in advertising and scope of practice that promote the physician-led health care team,” said Albany. “One is an ID badge law, which would inform patients the license under which that person is practicing. There’s another that addresses board-certification and places limitations on who can claim that they’re board-certified.” However, there are legal limitations to the AADA’s legislative reach with regard to these issues. “The Academy has to be careful of antitrust laws,” explained Albany. “We don’t want to be perceived as trying to prevent other professions from practicing — restricting their trade. We just want to protect patients, so that’s why we encourage our members to take action by contacting the medical boards when they observe an issue.”

“We just want to protect patients, so that’s why we encourage our members to take action by contacting the medical boards when they observe an issue.”

Unraveling insurance regulation

Many physicians’ least favorite things — step therapy, prior authorizations, modifier 25 — all fall under the purview of payers. But for physicians and patients struggling with coverage and reimbursement obstacles, re-writing the playbook can be difficult without a clear idea of who exactly is making the rules. “Plan regulations can be somewhat tricky,” said David Brewster, the AADA’s assistant director of practice advocacy. “Most plans are either provided by employers or fall under Medicare. While CMS regulates Medicare Advantage plans and plans offered through the federally facilitated marketplace, employer plans are a bit more difficult.”

To accommodate large companies with employees and operations across multiple states, Congress passed the Employee Retirement Income Security Act of 1974 (ERISA) streamlining employer-sponsored coverage to meet one federal standard as opposed to being subject to the individual insurance regulations of each state. “Because employer plans are protected under federal law, they’re immune to state-level regulations,” explained Brewster.

Plans offered within the exchanges, however, do fall under the regulatory authority of the states, although they must also meet certain coverage requirements specified by HHS. (Under the Affordable Care Act, all insurance plans are required to meet basic coverage requirements. Visit www.healthcare.gov/coverage/what-marketplace-plans-cover for more information on what these entail.)

Given that these major acronyms in health care are not always known for their accessibility, who then should dermatologists call when they’re faced with a payer issue in everyday practice? Brewster recommends that dermatologists who have an issue with a particular plan or insurer’s coverage go to the insurance company first. “It also doesn’t hurt to go to the insurance commissioner of that particular state either, although they have limited authority on a state-by-state basis.”

Stay informed!


Questions about code values?

Are you a rash whisperer?

Patch test. Identify allergens. Avoid them. If only it was that simple to diagnose and treat patients with allergic contact dermatitis.
While patch testing has been the gold standard for diagnosing allergic contact dermatitis (ACD) for a century, the key is combining the patient’s history and clinical examination with the results to determine the relevance of positive patch testing. That means asking the right questions, linking the answers to potential allergens, determining which patch tests are likely to yield the best results, having a good eye, and accurately interpreting the results. Once the offending allergens are identified, it requires educating the patient about how to avoid them. Those who do it well have earned the nickname the “rash whisperer.”
“I discuss everything... their workplace, home, hobbies, who they live with, and where they frequent. The second you don’t ask a question or don’t delve into some personal detail is when you miss something.”
Pros and cons of patch testing

Patch testing, however, is not an exact science. It’s suggested that the T.R.U.E. Test detects 66% of allergens, noted Christen Mowad, MD, director of the Contact and Occupational Dermatitis Clinic at Geisinger Medical Center. With expanded patch testing, that number is more like 80%. Customized panels can raise those numbers even higher.

It’s a very time- and labor-intensive process, especially when patients bring in their own products for testing. Staff has to learn how to prepare the trays and the nurse spends a lot of time with patients on their intake questionnaires. In a private practice, staffing and training would be an issue as would the cost of the tests, not to mention the time it takes for each appointment. “For a private practitioner who sees one patient every 15 minutes, there is not enough time to figure out potential allergens,” Dr. Murase added.

Patch testing is also time consuming and inconvenient for patients, who must come for a visit when the patches are placed on their back, return in two days for a patch reading, and return in five to seven days after that for a final reading. Patients can be itchy and uncomfortable if they have a reaction. Furthermore, some insurance companies have started to limit the number of patches they will cover. Insurance won’t necessarily pay for an additional 70-plus allergens after the patient has already had a T.R.U.E. Test, leaving the patient with additional expenses.

Patch testing is, however, the only thing that leads to a cure for ACD. Topical steroids can relieve the symptoms, but that doesn’t do much good if the patient continues to come in contact with the allergen, Dr. Murase said. Sometimes patients blame the medication for not working when the problem is that they are allergic to the steroid — which can be identified through patch testing.

To date, no other type of test is on the horizon to replace patch testing. A lymphocyte transformation assay has been shown to detect a delayed metal hypersensitivity, but it’s not widely available or covered by insurance, Dr. Mowad stated. Perhaps down the line, genomic studies might predict which patients will be allergic to what allergens, Dr. Brod said.

Importance of patient history, physical

In the meantime, the patient history provides clues to determine what allergens to test for. “This is where the detective work comes in,” Dr. Mowad stated. It begins with the questionnaire that asks about medications and personal care, household, and hobby-related products. Having the patient fill out a questionnaire in advance gives them time to reflect on all the products they use, Dr. Brod added. Past medical history and physical exam offer additional clues.

If the patient is a caregiver, it’s important to find out if it’s for an elderly person, infant, child, or pet as the allergen could be in products they are applying to somebody else’s skin, Dr. Mowad explained. Knowing their job title may not help identify potential exposures but learning what they actually do may. Sometimes the product itself is not the culprit, but what it is being applied with, such as a rubber applicator used to put on eye makeup. Products, and even medications, can cause an allergic reaction, even if the patient has been using them for a long time.

Dr. Zippin works off the patient intake questionnaire. “I discuss everything…their workplace, home, hobbies, who they live with, and where they frequent. One question begets another question,” he said. Dr. Zippin has learned not to shy away from asking questions because “the second you don’t ask a question or don’t delve into some personal detail is when you miss something,” he said. If fragrances are suspect, the incense that the patient’s roommate lights may be the allergen, so it’s not enough to ask if the patient uses incense. Asking questions after the patch test results are known is just as important. Dr. Zippin had a patient who developed a rash on the back of their legs. It turns out that the patient was allergic to a chemical in the cleaning supplies used on the toilet seats at their office. “I would never have come up with that before testing,” he said, “but the results provided some clues that led us to discover how the patient was coming in contact with the allergen.”
Dr. Murase added, “There is no clear, easy algorithm to follow. You take a detailed history and then figure out what is likely to be driving the rash.” Oftentimes, more than one allergen is at play in ACD. One of her patients is a baker who reported having reacted to some shampoos and sunscreens in the past. Dr. Murase tested the patient using a bakery, emulsifier, and sunscreen series. The patient was allergic to one baking ingredient, one fragrance, and one sunscreen ingredient. When the patient stopped using those products, they got better. Using just one supplemental panel may not have cleared the patient’s hands because the patient would still have been exposed to the other allergens, she said. “You also have to have a good eye to rule out ‘look alikes’ during the physical exam,” Dr. Murase added.

Pro tip: Consider using more than one supplemental panel. One of Dr. Murase’s patients is a baker who reported having reacted to some shampoos and sunscreens in the past. Dr. Murase tested the patient using a bakery, emulsifier, and sunscreen series. The patient was allergic to one baking ingredient, one fragrance, and one sunscreen ingredient. When the patient stopped using those products, they got better. Using just one supplemental panel may not have cleared the patient’s hands because the patient would still have been exposed to the other allergens.

Clinician interpretation
Expertise in interpreting patch test results is essential for diagnosing ACD. The accuracy of the test is dependent upon the skill set of the clinician interpreting the results, emphasized Dr. Brod. For example, experienced testers know factors that cause variability, so they patch test patients when their skin is less inflamed to minimize the risk of false positives and have patients avoid ultraviolet exposure and topical steroids for four weeks on their back prior to placing the patches. They also follow the proper process steps. Dr. Brod is always skeptical about the accuracy of a patch test when a provider only does the first reading. “Those delayed readings are really important because ACD evolves slowly over time,” he said. Up to one-third of positive reactions can be missed when the second reading isn’t done, Dr. Mowad added.

“The more you do it, the better you get at seeing subtleties and nuances that might be missed by someone who doesn’t perform patch testing that often,” Dr. Murase stated. For example, she now recognizes sister allergens that cross react. She knows that some allergens discolor the skin in a certain way and a pustular reaction to certain allergens can occur in a metal tray, both of which could be misinterpreted as a positive result.

“Contact dermatitis specialists have the experience and skill set plus the infrastructure to handle numerous trays and costs incurred from comprehensive patch testing,” said Dr. Zippin, who is the only dermatologist at Cornell who does patch testing. “The other dermatologists have come to the conclusion on their own that it’s too complicated,” Dr. Zippin said. “Even if they get positive results, they don’t know what to tell the patient effectively to avoid the allergen(s). It’s the same way that I refer to my Mohs surgeon to remove my patients’ skin cancers,” he added.

Patient education
Explaining what products the allergens might be found in and how to avoid them is as important as identifying them. To that end, ACDS members can access its Contact Allergen Management Program (CAMP) designed to help patients identify personal care products that are free of the ingredients that
may cause an allergic reaction. Each list generated is personalized for the patient and the CAMP app allows patients to access their list on their phone. The ACDS is developing a portal for patients and physicians that it hopes to launch in 2019 that will make educational materials and resources easily accessible to patients, said Dr. Murase, who serves on ACDS’s Board of Directors and is chair of the CAMP Optimization Task Force. Similarly, dermatologists can use SkinSAFE to generate a safe products list personalized for their patients, also available on an app. “Providing this type of information to patients is useful and empowering,” Dr. Murase said.

If the allergen is an occupational one, the patient should be given potential strategies to avoid it, Dr. Brod stated. That may include recommending implementing occupational safeguards such as keeping work surfaces clean, or personal hygiene practices, using protective equipment, and properly ventilating the area. For one of Dr. Mowad’s patients, it meant not touching the primroses that were on the table at the restaurant where they waitressed. ACD is one of most common causes of occupational diseases in the U.S., according to the AAD’s Burden of Skin Disease report, but up to half of allergens causing occupational dermatitis are missed, Dr. Murase noted.

Pro tip: Give the patient strategies to avoid the allergen.

According to the AAD’s Burden of Skin Disease report, ACD is one of most common causes of occupational diseases in the U.S. If the patient has an occupational allergen, the patient should be given potential strategies to avoid it. For one of Dr. Mowad’s patients, it meant not touching the primroses that were on the table at the restaurant where they waitressed.

Patients need to understand that not all allergens are created equal; some elicit a very powerful reaction while others elicit a mild reaction, Dr. Brod explained. “That means some allergens should be avoided at all costs, whereas the patient might be able to tolerate some products with very low levels of weaker allergens, even if the patient is allergic to one of them.” Patients should also be taught how to do a “use” test on their skin so they can tell if they will have a reaction before using a product on a widespread basis.

ACD may not be simple to diagnose, but it is rewarding for the rash whisperers. Dr. Brod also finds it very humbling. “I’ve learned that we’re not always good at predicting what the allergen will be prior to patch testing,” he said. “That has taught me the value of performing it.” Dr. Murase reads patch testing differently now than when she started 12 years ago.

“I’ve grown to appreciate and respect how complex and subtle ACD can be, and I understand how profoundly a single test can improve patients’ lives.”

Justifying comprehensive patch testing with insurers

A Review of the Medical Necessity of Comprehensive Patch Testing supports the importance of performing advanced specialty trays above and beyond the T.R.U.E. Test, and the ACDS and NACDG series to further identify relevant allergens based on a patient’s history and potential exposures (Dermatitis. 2018. 29(3):107–111). It can be used to approach insurance companies to justify the number of patches a patient requires for a thorough evaluation. In addition, ACDS members can use a letter posted on its website (www.contactderm.org/i4a/ams/amslogin.cfm), in conjunction with the article, to process the necessary prior authorizations for insurance companies.
January often calls us to make a fresh start. This doesn’t just apply to people looking to lose weight, organize their closets, or volunteer more. The New Year marks a fresh start for state and federal policymakers. Many statehouses are setting up shop for the year this month. In Washington, D.C., we have a few new faces and many incumbents who will make up the 116th United States Congress. It’s a clean slate in the health care policy world, and dermatology is ready to make its mark.

Fortunately, your Academy has a robust advocacy arm, the American Academy of Dermatology Association (AADA), that provides a consistent voice for dermatologists. The AADA ensures that public policies address the needs of practices and patient care and provides members with valuable resources and tools to adapt to the shifting health care landscape. Thanks to the advocacy efforts made by the AADA and Academy members, the specialty celebrated several successes in 2018, including increases in skin cancer research funding and legislation that addressed patient access to care. Most recently, CMS delayed a proposal to collapse E/M codes and backed away from aggressive changes to modifier 25 payments.

However, 2019 brings a whole new set of opportunities and challenges. This year, you can expect our AADA to continue its work advocating for relief from burdensome regulations and requirements on dermatologists. The Academy will work to protect patient access to care — specifically, advocating against restrictions on dermatology in-office compounding and in-office use of compounded pharmaceutical products. At the state level, we will continue to fight for indoor tanning regulations and sunscreen access, and we will remain steadfast in promoting truth in advertising and advocating against unsafe expansions of non-physician provider scope of practice.

This is just a taste of what you can expect from our Academy’s advocacy efforts — we have a lot of issues to address at the health policy level. As a result, we’ll need all the help we can get. WE NEED YOU! Make a January resolution to be an advocate for dermatology practice. It’s easier than you think! Check out the AADA’s Advocacy Action Center to learn how you can get involved at https://takeaction.aad.org. Also, mark your calendars for the 2019 AADA Legislative Conference, Sept. 8-10, in Washington, D.C. Registration will open May 13.

As a specialty, we accomplished a great deal in 2018. Let’s use that momentum and resolve to do more to advocate on behalf of our patients and practices in 2019. dw
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It has been a true honor and distinct privilege to serve the American Academy of Dermatology and Association as vice president this year. Serving the organization, however, really means serving you, the members who comprise the AAD/A. I have approached every discussion and each decision by thinking about what would benefit the members who elected me — not to “govern” but instead to represent them. While this sounds deceptively easy, it has often proven to be a relatively difficult task. Viewed through the lens of various recent and significant challenges, we are sometimes quite united. A discounted modifier 25, collapse of E/M codes, defending scope of practice, proper professional identification and truth in advertising, the burden of MACRA and MIPS, and the compounding conundrum are examples of issues that bring us solidly together. On the other hand, how to approach maintenance of certification, the entrance of private equity into the dermatology space, what constitutes an unacceptable conflict of interest, and the degree of supervision required for non-physician providers are examples of issues that produce legitimate differences of opinion. Unfortunately, those differences of opinion tend to divide us and have even fostered vitriolic and publicly voiced ill-will between us.

If there is anything that I have learned this year, it is that a very old phrase, “United we stand, divided we fall,” is profoundly correct. This is not a new idea, as it can be traced back to several fables by Aesop — a Greek storyteller who lived during the sixth century B.C. — as well as multiple bibli-cal passages. The same concept was repeated in patriotic American songs penned in 1768 and 1853, as well as in modern music by Brotherhood of Man (1970) and Pink Floyd (1979). From Patrick Henry, who espoused this concept during his last public address in 1799 to J.K. Rowling, who used a variation of the phrase in *Harry Potter and the Goblet of Fire* (2000), the idea of strength in numbers has stood the test of time.

Dermatology makes up only about 1% of the physician workforce in the United States. If we are to be effective and efficient at seeking regulatory relief, if we are to succeed in advocacy efforts, if we strive to elevate the opinion held about dermatologists by the general populace and the house of medicine alike, we must do so as a united specialty. We must seek compromise, collaboration, and common ground to foster strength in numbers. Pediatric and adult medical dermatologists, surgical dermatologists, aesthetic specialists, private practitioners, and academics are all really dermatologists first. I implore all of you reading this piece to join hands with your colleagues to make our mutual specialty as strong as possible. I furthermore urge every Academy member to volunteer and serve our organization. The AAD/A staff is remarkably talented, extremely hard-working, and dedicated, but they need your help, ideas, and guidance in order to meet today’s challenges and chart tomorrow’s future. I will close by quoting Albus Dumbledore, of Harry Potter fame: “We are only as strong as we are united, as weak as we are divided.”
Learn the latest in dermatology at over 375 educational sessions, meet with other dermatologists from around the world, discover new products and services from over 400 exhibitors, and bring new information back to your practice. Plus, when you’re not in session, explore the monuments and museums, and experience the art, culture and history of Washington, DC.

While registering, you can also save on select AAD products and make a donation.
in your corner
addressing issues in the specialty

What is the Academy doing to ease the administrative burden on physicians?

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. Additionally, the Academy has developed several tools and resources for physicians to help ease the administrative burden.

**Advocacy activities:**
The Academy advocates for relief from administrative activities that redirect valuable time away from patient care, such as onerous step therapy, prior authorizations, and documentation requirements.

As part of its advocacy efforts, the AADA:

- Successfully advocated for laws that protect against step therapy protocols in 18 states.
- 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.
- Supported provisions in the 2019 Medicare Physician Fee Schedule that simplify E/M documentation by requiring that physicians only document changes to history and physical exam for established patients.

Learn more

Get the latest news on what the AADA is doing to advocate for physician relief from administrative burdens at www.aad.org/advocacy/news.
Resources for physicians:
The Academy offers several resources for physicians at its online Practice Management Center. Here are a few highlights:

- Easily create appeal letters to help overturn denials for prior authorizations with the Academy's prior authorization letter generator.
- Access resources to reduce burnout by overcoming practice challenges associated with EHR burdens, insurance denials, and online reviews.
- Find information about common coding issues and understand all of the coding changes for this year.
- Get everything you need to ensure your practice is compliant with the ACA, HIPAA, CLIA, the Sunshine Act, iPLEDGE, and OSHA.
- Easily understand how to comply with the MIPS program in the MACRA Resource Center, and fulfill MIPS reporting requirements through the Academy's data registry, DataDerm™.

Check out the AADA’s practice management tools and resources at [www.aad.org/practicecenter](http://www.aad.org/practicecenter).
2019 Annual Meeting registration and housing available online

Register online to attend the Academy’s 2019 Annual Meeting in Washington, D.C., March 1-5 at 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. 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™. New 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. – SUSAN JACKSON

Save the date: Tropical Dermatology in Tanzania
Tropical Dermatology in Tanzania: A Unique Experience at the Regional Dermatology Training Centre will be held in Moshi, United Republic of Tanzania, Jan. 11-13, 2020. For more information, visit www.aad.org/meetings/tropical-dermatology-in-tanzania.

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.

• 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)
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Recruitment Advertising
Navaderm Partners ................................................. 59
Medical vs. cosmetic dermatology: Who is doing what?

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Despite ongoing discussion about the role of cosmetics in the specialty, data from the 2017 AAD Practice Profile Survey indicate that medical dermatology remains the primary focus of dermatology practitioners across all types. However, dermatologists spend the least amount of time on medical dermatology in comparison to other providers, diverting attention in favor of non-cosmetic surgical dermatology.

The data also reveal that nurse practitioners appear to perform more cosmetic dermatology than other provider types. These findings remain consistent across practice settings — with a few exceptions. For example, nurse practitioners in academic settings perform significantly more medical dermatology, as do dermatologists in multispecialty settings. For a full breakdown of area of treatment by provider type, see the chart below.

Area of treatment by provider type

<table>
<thead>
<tr>
<th>Area of Treatment</th>
<th>Dermatologists</th>
<th>Physician Assistants</th>
<th>Nurse Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>63%</td>
<td>76%</td>
<td>74%</td>
</tr>
<tr>
<td>Non-cosmetic surgical</td>
<td>25%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>12%</td>
<td>11%</td>
<td>17%</td>
</tr>
</tbody>
</table>

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