Technology vs. skin cancer

A new generation of non-invasive tools and apps reduces unnecessary biopsies, promotes self-surveillance

12 Private equity at a glance.

32 Tips for reducing the burden of EHR clinical documentation

40 What’s new with connective tissue disease?
TOP 5 REASONS TO ATTEND:

1. Learn about the latest advances in dermatology.
2. Discover valuable information that can be applied to everyday practice.
3. Connect with colleagues in a casual setting.
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IMPORTANT DATES

EARLY BIRD REGISTRATION ENDS:
Wednesday, June 19
12 p.m. noon (CT)

HOUSING DEADLINE:
Friday, June 28
12 p.m. noon (CT)

aad.org/summer19
You asked, we listened.

We had an outstanding response to our readership survey this year (thanks to all of you who took the time to offer your thoughts and opinions!) and, overall, we seem to be doing a good job of offering relevant and timely content to our readers. Many dermatologists trust us as their primary source of information regarding practice management and health policy issues. We got some great suggestions for new topics, many of which have been added to our lineup for the upcoming year, and we heard you about subjects you feel we have covered sufficiently (enough on burnout?). We renewed our commitment to making Dermatology World user-friendly, and as a result, you may notice a few changes in the layout and organization of our magazine this month. We have bundled our columns by subject matter (clinical, practice management, Academy news) to make it easier to find related articles. Our popular feature articles have moved up front in the magazine. To help you not miss any of Dr. Warren Heymann’s popular DW Insights and Inquiries, we added a column in Dermatology World Weekly and the DW print magazine that highlights the latest topics. And, in case you were wondering what happened to Acta Eruditorum, never fear…it’s still here, just renamed Clini-

While the look of DW has changed somewhat, the feel is hopefully the same. We have a great lineup of articles this month that address issues of importance to all of us in practice. Did you realize as a health care worker, your risk of experiencing workplace violence is significantly higher than that of most other workers? I encourage you to read doctor-lawyer Cliff Lober’s Legally Speaking column this month to learn more about early warning signs of impending violence and what steps you and your office may want to take to mitigate this risk. You may also want to learn more about protecting your financial assets in this month’s Money Matters. David Snyder, JD, CLU, offers a helpful guide to the ins and outs of disability insurance. And, of course, we can’t have a complete edition of DW without tackling one of your favorite topics: coding! This month we explore what happened to Acta Eruditorum, never fear…it’s still here, just renamed Clinical Applications to better reflect the intent of the conversation we have every month with authors of high-impact journal articles.

June brings us closer to July and the Summer Meeting! David Ozog, MD, and members of the Scientific Assembly Committee have put together what promises to be an outstanding meeting, covering hot topics of interest to all who practice dermatology. And who can resist a long weekend in New York City? It’s not too late to make plans to join us. I hope to see you there!
DERMATOLOGY WORLD WEEKLY

In your inbox every Wednesday with the most important news for dermatology. Missed an issue? We keep an archive of recent issues online.

DW ACADEMY INSIDER

Weekly updates from the Academy, selected just for you based on your preferences. Look for it every Thursday!

DW INSIGHTS & INQUIRIES

Get the latest in the dermatologic literature with Dr. Warren Heymann.

FEATURES

12
PRIVATE EQUITY AT A GLANCE
A visual guide to private equity’s presence within the specialty.

24
TECHNOLOGY VS. SKIN CANCER
A new generation of non-invasive tools and apps reduces biopsies and promotes self-surveillance.

40
BREAKING THROUGH
Advances in disease pathogenesis and treatments offer new promise for patients with connective tissue disease.

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

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

08 CLINICAL APPLICATIONS
Researchers discuss using a prognostic 31-gene expression profile to identify patients at risk of melanoma metastasis.

11 INSIGHTS AND INQUIRIES
Warren Heymann, MD, and members of the DW Insights & Inquiries editorial board discuss onychomycosis, cherry angiomas, skin and stress, and more.

20 CRACKING THE CODE
Alex Miller, MD, discusses Medically Unlikely Edits and MUE Adjudication Indicators.

32 ANSWERS IN PRACTICE
Reducing the burden of clinical documentation with EHRs.

34 LEGALLY SPEAKING
Find out what you need to do to address workplace violence in your practice.

36 MONEY MATTERS
Learn more about how to protect your ability to practice with disability insurance.

46 FROM THE PRESIDENT
Academy President George Hruza, MD, MBA, discusses member engagement and volunteerism.

48 IN YOUR CORNER
What is the Academy doing to educate members about appropriate coding and billing?

50 ASKED AND ANSWERED
You asked, we answered: What resources does the Academy offer on the new biopsy codes?

52 WATER COOLER
This column features the thoughts of readers like you! This month we asked, “Does your institution or practice provide child care? If so, what does it entail?”

54 ACADEMY UPDATE
Obituaries

58 CLASSIFIEDS

60 FACTS AT YOUR FINGERTIPS
Who owns and manages dermatology practices today?
Positively Mineral™
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What’s hot?

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

Oral tofacitinib, a Janus kinase (JAK) inhibitor, is an emerging pathogenesis-directed treatment for alopecia areata (AA), and can be a promising therapeutic option for children. A case series in 13 adolescents (J Am Acad Dermatol. 2017;76:29-32) receiving oral tofacitinib showed 70% of patients experiencing regrowth over a median of five months (range 2-16 months), and a more recent case series of four preadolescent patients (https://doi.org/10.1016/j.jaad.2018.08.041), ages 8-10, demonstrated regrowth in 75% of patients between three and six months on treatment. In both studies, dosing of 5mg BID was used and well tolerated. In the adolescent study, one non-responsive patient had AA for >12 years, mirroring data in adults where it has been observed that those with >10 years of disease were less responsive to oral tofacitinib. This could support the argument for early treatment of alopecia areata during onset in childhood and adolescence to prevent potentially irreversible hair loss. Though the sample sizes were small, oral JAK inhibitors should be considered, especially in patients experiencing psychologic impairment and negative effect on quality of life. Currently there are no long-term safety data in the pediatric population with oral JAK inhibitors and proper counseling regarding the risks, including severe infection and malignancy, should be had with patients and families.

There are several FDA-approved options available for field therapy for the treatment of multiple actinic keratoses, including photodynamic therapy, ingenol mebutate, imiquimod, and 5-flourouracil. In a recent study from the Netherlands, investigators compared each of these options head-to-head in 624 patients with five or more actinic keratoses of the head and neck area (N Eng J Med. 2019; 380(10): 935-46). The treatment duration differed for each agent based on current recommended course, and patients could be re-treated with the same regimen once, if they did not meet the criterion of 75% clearance. All patients also received superficial curettage of lesions prior to therapy.

At 12 months after the end of the first treatment, 75% of patients treated with 5% 5-flourouracil cream maintained a 75% reduction in the number of actinic keratoses (primary outcome), compared to 56% of patients receiving imiquimod, 38% receiving MAL-PDT, and 29% receiving ingenol mebutate. Additionally, patients receiving 5-flourouracil were least likely to require a second course of treatment at follow-up after completion of initial therapy. Among patients treated with 5-flourouracil, 15% required a second course of treatment, which was superior to MAL-PDT, imiquimod, and ingenol mebutate (35%, 37%, and 48% respectively).

As might be expected, compliance was greatest for those receiving one-time treatment (MAL-PDT; 97%) and a three-day course of therapy ingenol mebutate; 99%), compared to four weeks of treatment with imiquimod (88%) or 5-flourouracil (89%). In addition, compliance with four weeks of treatment could be expected to be even lower in the real-world setting. Nonetheless, these data suggest that 5% 5-flourouracil cream provides superior long-term clearance of actinic keratosis in comparison to more recently approved field therapies.

Moving target

Allergic contact dermatitis is a common dermatologic problem that we all encounter on a routine basis. Patch testing is the criterion standard for diagnosing this condition. A recent *Dermatitis* study evaluates the effectiveness of patch testing on improving allergic contact dermatitis and looks at prognostic factors that affect the clinical outcome and ability of patients to recall detected allergens (2019. 30(2): 135-141). The authors looked at 111 patients who were evaluated with Investigator Global Assessment (IGA) scores and Dermatology Quality of Life Index (DQLI) pre and post patch testing. They were divided into two groups: those that had relevant positive allergens detected, and the control group that did not have any relevant allergens. The authors found that in patients where allergens were found and avoidance instruction was provided, there was improvement in IGA and DQLI six months after testing. They also found that 75% of patients correctly remembered their allergens. This percentage was higher and more significant in patients who were female and who had higher baseline IGA and DQLI. Recollection of allergens was lower in those with greater than one allergen. More positive reactions to allergens also resulted in less improvement of IGA and DLQI, underscoring the difficulty associated with high number of allergens — given the need for more extensive lifestyle changes and difficulty in compliance.

This study reinforces the benefits of patch testing on the clinical course of contact dermatitis. It also highlights the necessary role of education in the management of ACD patients. Patients who made lifestyle changes and remembered and avoided allergens had the most significant improvements in IGA and DLQI. This study reminds us that we can significantly impact our patients with ACD, their clinical involvement, and quality of life through patch testing, education regarding allergen avoidance, and follow up. dw
Using gene expression profiling to identify risk of melanoma metastasis

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Sancy Leachman, MD, PhD, about her recent JAAD article, “Identification of patients at risk of metastasis using a prognostic 31-gene expression profile in subpopulations of melanoma patients with favorable outcomes by standard criteria.”

Dr. Schwarzenberger: Can you address the recent AAD guidelines that do not advocate routine gene expression profiling (GEP) testing on melanoma patients?

Dr. Leachman: The AAD Guidelines Committee evaluated all the available literature to support all practices in the diagnosis and care of melanoma patients. This committee was comprised of experts in our field and they did not feel that the data currently available supported inclusion of the GEP in standard practice at this time. However, this committee is also creating guidelines, not unbreakable rules, and the test is available on the market. Guidelines are intended to be just that, a recommendation by experts for most cases and because they are intended to be applied broadly, it is usual that they are conservative with a high bar for data, and in keeping with this philosophy this committee did not recommend routine use of this test for any melanoma.

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Dr. Schwarzenberger: How should GEP fit into our practice?

Dr. Leachman: There are certainly cases where this test is useful, and there are other experts in the field who feel that it is time for the test to begin transitioning into clinical practice. It is unclear what bar is required before transition to standard practice begins to happen — this is a “competing good” for patients, a balance between having enough assurance that the test is not leading to anything unsafe and the assurance that we are pushing the field forward in a positive way.

When technology is in the transition period between being a research-only test and a standard-of-care test, there is an accompanying period of uncertainty about its appropriate use. In this transition period, when it is available on the market, but has not yet been incorporated into formal guidelines, the “art of medicine” needs to be applied and every patient’s case needs to be assessed individually. It is not appropriate for the test to be used on everyone, nor is it appropriate to withhold the test from someone who might benefit from it. As the test transitions further into the clinical realm, the most appropriate population(s) of patients to receive the test will become more apparent, larger data sets will be analyzed, costs will likely come down, and rational guidelines will be set for use.

Dr. Schwarzenberger: Do you anticipate that GEP will eventually transition into regular clinical practice?

Dr. Leachman: An analogy might be the transition from horse and buggy to the automobile. Certainly,
the horse was a reliable means of transportation and the auto was less proven, less affordable, and perhaps even less reliable in the beginning. But the auto was faster and didn’t require as much food/labor to keep healthy, and costs came down so that it was affordable for a large percentage of the population. I predict the GEP test will transition in a very similar way. Through use in the larger community, its true utility and the appropriate populations in which it should be used will emerge.

**Q** Dr. Schwarzenberger: During this transition period, are there certain cases and situations in which GEP could be helpful in providing additional information?

**Dr. Leachman:** GEP doesn’t override gold-standard practices, but it superimposes an additional knowledge that can be used to inform difficult and/or equivocal cases. Knowledge is power in these cases, for both the provider and patient. The knowledge may be helpful whether the test is positive or negative as well. For example, a positive (class 2) test may not yet come with enough certainty about outcome to be able to use it to recommend adjuvant therapy, but it can help increase the frequency and intensity of surveillance so that a recurrence will have a greater likelihood of being caught earlier when the tumor burden is less and more treatable.

Similarly, though most thin melanomas are negative (class 1), there are some highly anxious or knowledge-driven individuals who would benefit from that reassurance. In my opinion, what is most vital during the transition period is to have rational, data-based debate among experts with differing opinions, because this offers the greatest chance for successful implementation of a useful test in the right people at the right time. It’s okay that we don’t agree, it means that there is not yet a clear right or wrong answer about the use of the test, but — like every new technology successfully implemented in medicine — we are navigating through the uncertainties as we go.

**Q** Dr. Schwarzenberger: What should we do with the results? Our present standard of care does not mandate evaluation beyond serial skin and node exams in patients with early-stage disease. Should we consider ordering imaging on a regular basis for patients deemed high risk by GEP?

**Dr. Leachman:** My standard practice is to use the test results as a piece of information that guides care of the patient (i.e., this is not a test that is associated with something I feel the patient must...
If a patient has a thin melanoma that would otherwise not be sent for a sentinel lymph node biopsy, but has a class 2 GEP, I would discuss a possible sentinel lymph node biopsy (or refer for that discussion). If the sentinel lymph node biopsy was not performed or was negative, I would work with surgical oncology to follow the patient more intensely (joint follow-up with surgical oncology, decreased threshold for imaging studies, or biopsy, etc.). If the sentinel lymph node was positive, this patient would then have the option of adjuvant therapy.

If a patient with a thicker melanoma that receives a sentinel lymph node biopsy has a class 1 test result and a negative sentinel node biopsy, the surveillance can be decreased, and it is appropriate that they are followed primarily in dermatology. In terms of the imaging I would consider, it would be driven by the symptoms of the patient and would not change in the type of study, just the threshold I have for requesting it. Ultimately, if the patient reports symptoms, it is a “judgement call” regarding whether the sign or symptom is concerning enough to warrant ordering a study (e.g., fine-needle aspiration, ultrasound, MRI, or PET-CT). My threshold for a sign or symptom triggering the ordering of such a study is much lower if the patient has a class 2 test.

**Dr. Leachman:** Yes and no. At this point, we do not know enough about the overlap between the tests to know that one test is sufficient. Some of the decision regarding whether to order the GEP test depends on whether the GEP or the SLN biopsy is done first. If the SLN is positive, then the GEP can superimpose additional prognostic information on that and may influence a patient or provider one way or another about whether to offer adjuvant therapy to a given patient. The bottom line is that the GEP just adds additional information for consideration in the decision-making process, it doesn’t mandate an action. As it becomes more mainstream, that may change and having a class 2 result may be considered reliable enough and high-risk enough to guide the recommendations for adjuvant therapy.

**Dr. Schwarzenberger:** What is the future of GEP?

**Dr. Leachman:** I think that these tests are going to become more and more mainstream and will become an integral part of our practice to guide screening and care. Like the automobile, once there is an accepted test, the competition will roll in and we will benefit from better, more efficient, and less expensive tests. Right now, we must accept and tolerate the evolution we are going through to get there and use our best judgement for each patient. If we do, we will all benefit.
Don’t miss this month’s Insights!

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

• Breaking the terbinafine laboratory habit for onychomycosis

• Life is just a bowl of cherry angiomas

• Stress² + Hormones² = Acne²

• Taking the challenge: Social media, adolescents, and the skin

• The newest frontier for biologics and psoriasis may be adherence

Look for DW Insights & Inquiries every Wednesday in DW Weekly, or go online to www.aad.org/dw/dw-insights-and-inquiries to read the latest and search the archives.
Private equity at a glance

A visual guide to private equity’s presence within the specialty
Since private equity’s debut into dermatology, its presence has sparked spirited debate among dermatologists about its impact on physician autonomy, patient care, and administrative burden. While *Dermatology World* has led discussions about the wider implications of a marriage between venture capital and health care (see July 2016’s “Skin in the game,” and January 2018’s “Pulling back the curtain on private equity”), a clear picture of the current size and scope of private equity’s influence can be elusive.

To help make sense of the steady pace of acquisitions, mergers, and occasional failed venture, this month *Dermatology World* presents a visual guide to the dermatology private equity landscape, by tracking:

- Regional influence
- The biggest deals in dermatology
- Key stats on major players
- Top 5 largest groups
- Year-by-year growth within the specialty
- Groups that have expanded the most >>
MAPPING OUT PRIVATE EQUITY OWNERSHIP

While some private equity groups are regionally focused, others have a nationwide presence. See which groups are most prominent in your state.
BIGGEST DEALS IN DERMATOLOGY

While some private equity firms can have millions to billions of dollars’ worth of capital at their disposal, how much are they spending on dermatology? Check the chart below for some of the biggest dermatology deals. (Note: This list includes transactions whose financial terms were disclosed. Other transactions may have been larger.)

1. $600 million: Advanced Dermatology & Cosmetic Surgery (ADCS) by Harvest Partners, LP
2. $450 million: Forefront Dermatology by OMERS Private equity
3. $300 million: US Dermatology Partners by ABRY Partners
4. $58 million: Dermatology Solutions Group by Cressey & Company*
5. $35 million: Schweiger Dermatology Group by LLR Partners and SV Health Investors**
6. $33 million: Riverchase Dermatology and Cosmetic Surgery (Riverchase DCS) by GTCR LLC
7. $31.8 million: QualDerm Partners, LLC by Cressey & Company and Apple Tree Partners
8. $25 million: Adult and Pediatric Dermatology by Waud Capital
9. $20 million: Schweiger Dermatology Group by Triangle Capital

*No longer backed by Cressey & Company  **No longer backed by LLR Partners and SV Health Investors
**TOP 5 LARGEST EQUITY-BACKED GROUPS**

1. **Advanced Dermatology & Cosmetic Surgery**: 168 locations
2. **Forefront Dermatology**: 139 locations
3. **US Dermatology Partners**: 66 locations
4. **Anne Arundel Dermatology**: 58 locations
5. **Dermatologists of Central States**: 54 locations

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**THE MAIN PLAYERS**

While the precise number of equity-backed dermatology groups is constantly in flux, use this guide for key information on players who currently have skin in the game. Visit [www.aad.org/dw](http://www.aad.org/dw) for a full list.
MOST RAPID GROWTH

As more private equity groups enter the market, which have had the most rapid expansion? Check the chart below.

1. **Platinum Dermatology**
   - 16 new locations
   - 107% since 2017

2. **Anne Arundel Dermatology**
   - 25 new locations
   - 76% since 2017

3. **Tricenna QualDerm Partners, LLC**
   - 10 new locations
   - 71% since 2017

4. **Epiphany Dermatology**
   - 9 new locations
   - 64% since 2017

5. **Epiphany Dermatology**
   - 12 new locations
   - 52% since 2017

*Growth estimates are calculated based on expansion from 2017 to 2019, pending available data.*
Private equity at a glance

EVOLUTION OF OWNERSHIP

Critics of private equity note that physicians and their staff are subject to new ownership at the whims of the market. Find out which equity-backed dermatology groups have changed hands, how many times, and which groups have exited the market entirely.

No longer PE-backed:

- **Dermatology Solutions Group (DSG).** Still retains practices in Alabama, Florida, Georgia, and Mississippi. DSG was formerly backed by Cressey & Company, who acquired them in August 2013 for $58 million. However, they ended their partnership in May 2015 and DSG is currently listed as being physician-owned with no known backers.

Defunct:

- **DermOne (formerly Accredited Dermatology).** Originally backed by Westwind Investors, who acquired DermOne in February 2012 for an undisclosed amount, DermOne partner practices were eventually acquired by PE-backed dermatology group Schweiger Dermatology Group in March 2018.

Changed hands:

- **Forefront Dermatology.** Formerly backed by Varsity Health Care Partners, who acquired Forefront in May 2014 for an undisclosed amount. Forefront was subsequently acquired by OMERS Private equity in February 2016 for $450 million.

- **Riverchase Dermatology and Cosmetic Surgery (Riverchase DCS).** Formerly backed by Prairie Capital, who acquired Riverchase DCS in December 2012 for an undisclosed amount. Riverchase DCS was then acquired by GTCR in October 2016 for $33 million.

- **Schweiger Dermatology Group.** Formerly backed by SV Health Investors (formerly SV Life Sciences), who acquired Schweiger in January 2015 for an undisclosed amount. In May 2016, LLR Partners joined SV Health investors in May 2016 in support of Schweiger with a $35 million investment. Schweiger has since been acquired by Triangle Capital in June 2017 for $20 million.

- **US Dermatology Partners.** Formerly backed by Candescent Partners, who acquired US Dermatology Partners in January 2013 for an undisclosed amount. US Dermatology Partners has since been acquired by ABRY Partners in May 2016 for $300 million.

- **Advanced Dermatology & Cosmetic Surgery (ADCS).** Formerly backed by Audax Group, who acquired ADCS in October 2011 for an undisclosed amount. ADCS has since been acquired by Harvest Partners in May 2016 for $600 million.

- **Sona Dermatology & MedSpa.** Formerly backed by Carousel Capital Partners, who acquired Sona in November 2007 for an undisclosed amount. Sona has since been acquired by Pharos Capital in December 2015 for an undisclosed amount.


**EXPANSION OF PRIVATE EQUITY IN DERMATOLOGY**

![Graph showing the expansion of private equity in dermatology practices from 2007 to 2018.](image)

**DERMATOLOGY PRACTICE OWNERSHIP**

<table>
<thead>
<tr>
<th>Ownership Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatologist Owners</td>
<td>57%</td>
</tr>
<tr>
<td>Health system/Hospital/Academic Center</td>
<td>24%</td>
</tr>
<tr>
<td>Private equity-backed</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

For more details about who owns and manages dermatology practices, flip to p. 60.
MUE, MAI, and you

BY ALEXANDER MILLER, MD

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

A Medicare-insured patient travels some distance from his rural home to see you about several recurrently bleeding skin lesions. You identify six individual lesions suspicious for infiltrating morpheaform basal cell carcinomas. Since the patient traveled far to your office, you offer to biopsy all six of the lesions on the same day. You do six individual punch biopsies, each on a separately identifiable lesion, and report the biopsies with CPT code 11104 and 11105 X 5. Your Medicare Administrative Contractor (MAC) adjudicates the claim and denies payment for some of the biopsies. What happened?

All the biopsies were medically reasonable and necessary.

The answer hinges upon the Centers for Medicare and Medicaid Services (CMS) Medically Unlikely Edits (MUE) table. MUEs exist to reduce Medicare Part B claims payment errors. The MUE table lists the maximum unit(s) of a specified CPT/HCPCS code that would typically be reported for services done on one patient, on one day. Most CPT codes that are assigned MUEs are published by CMS. These can be found at www.cms.gov/medicare/coding/nationalcorrectcoding/mue.html. Some MUEs are not published and are not made public. This is intended to guard against abuse. Fortunately, MUEs for codes used by dermatologists are nearly all published and readily accessible. Knowing the MUEs will allow one to either stay within the MUE parameters when providing services or to be prepared for a claim denial and subsequent appeal.

The answer hinges upon the Centers for Medicare and Medicaid Services (CMS) Medically Unlikely Edits (MUE) table. MUEs exist to reduce Medicare Part B claims payment errors. The MUE table lists

<table>
<thead>
<tr>
<th>HCPCS/ CPT Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT Instruction</td>
</tr>
<tr>
<td>11103</td>
<td>6</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Clinical: CMS Workgroup</td>
</tr>
<tr>
<td>11104</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT Instruction</td>
</tr>
<tr>
<td>11105</td>
<td>3</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Clinical: CMS Workgroup</td>
</tr>
<tr>
<td>11106</td>
<td>1</td>
<td>2 Date of Service Edit: Policy</td>
<td>Code Descriptor / CPT Instruction</td>
</tr>
<tr>
<td>11107</td>
<td>2</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Clinical: CMS Workgroup</td>
</tr>
</tbody>
</table>

Let’s return to the six punch biopsies billing scenario discussed above. All biopsies were of separately identifiable lesions, and all were medically necessary. What does the MUE table tell us?

NEW: Coding resources

Find practical tips, tools, quizzes, and videos about common dermatologic coding issues at the Academy’s new Coding Resource Center at www.aad.org/coding-resource-center.
CPT code 11104, punch biopsy, has an MUE of 1. That makes sense, as the code describes a single lesion punch biopsy procedure. There can only be one single lesion. Separate/additional punch biopsies are reported with CPT code 11105. The MUE table limits additional punch biopsies to three. That means that whenever one does more than four punch biopsies in one day on the same patient, your MAC is not likely to cover the entire service even if it is totally reasonable and necessary. By now you must have noticed the MUE Adjudication Indicator column along with the MUE Rationale column. What are those?

MUE Adjudication Indicators (MAI) specify three types of claims adjudication parameters, identified by numbers 1, 2, or 3. A MAI of 1 is a claim line edit, which means that each reported service is adjudicated as a claim line edit. This type of edit facilitates a simple billing bypass of the MUE edit limits by reporting services that exceed an MUE on a separate claim line. For example, if a service has an MUE of 3, but you perform four units of the service, you could report three units of the service on the first line of the claim and an additional unit of the service on a subsequent line of the claim. This approach would bypass the MUE edit and the claim would be adjudicated and would pay for all four units of the service. Realizing that this could change the intent of the MUE values, CMS has transitioned the majority of MUEs to MAIs of 2 or 3.

MAIs of 2 are date-of-service edits that are absolute, based upon policy, such as CPT code definitions. For example, skin biopsy codes 11102, 11104, 11106 all have MAIs of 2. The rationale for this MAI is described in the MUE Rationale column of the MUE table. In this case, the reasoning is straightforward: all three of these codes are limited to the first (single) biopsy. As there can only be one first biopsy of a given type, each of the biopsy codes carries an MAI of 2. Similarly, CPT code 17000, destruction of premalignant lesions, also has a MAI of 2, as there can only be one “first lesion” destruction.

MAIs of 3 specify date-of-service edits, meaning “per day.” For example, additional tangential biopsies, CPT code 11103, have an MUE of 6 and MAI of 3. This means that in addition to the first tangential biopsy, CPT code 11102, one may do six additional biopsies on separately identifiable lesions on the same day, report them for that date of service, and be eligible for payment by the MAC. Any additional tangential biopsies beyond seven done on one day on a given patient will not be payable, regardless of whether the services are reported on one claim line or multiple claim lines. MAIs of 3 are generated based upon “clinical benchmarks.”

CMS realizes that there may be reasonable clinical instances where one may exceed the MUE for services that have MAIs of 3. Consequently, one may appeal reasonable and necessary services that are automatically denied based upon MUEs with MAIs of 3. Such appeals may be done via claims reopening or redetermination.
Example 1

You suspect that your service billable to Medicare will exceed its MUE value. You have your patient sign an Advanced Beneficiary Notice of Noncoverage (ABN) prior to performing your service, in order to assure payment for any portion of the service in excess of the MUE.

Answer: Incorrect. CMS points out that denials of payment based upon MUEs are coding policy denials rather than medical necessity/non-covered services denials. ABNs are intended for use when a service may be denied based upon a lack of medical necessity. When a denial is based upon coding parameters, an ABN will not shift the payment liability to the patient. Conclusion: ABN or not, when a payment denial is based upon incorrect coding or MUE parameters, the patient is not liable for payment.

Example 2

You punch biopsied six separately identifiable lesions on a Medicare patient and submitted a claim as follows:

11104
11105 X 5

You receive payment from your MAC for the first biopsy. All five of the rest are denied with the following explanations: CO (contractual obligation) and N362 and MA01, indicating that the units of service on the claim line exceeded the MUE number.

Answer: Correct. The total MUE for punch biopsies is 4, so you would have expected three out of five 11105 units to have been reimbursed. Not so. CMS policy is that when a claim line’s units of service exceed the MUE, the entire claim line is denied. When your units of service exceed the MUE, it is best to partition that service line and bill the excess units on separate claim lines. Four of the six punch biopsy codes would have likely been adjudicated as payable if the claim were submitted as follows:

11104
11105 X 3
11105-76 X 2

Check with your private payers on their policy for the use of modifier 76 when the same exact procedure is reported on a separate line of the same claim.

Example 3

You do four incisional biopsies on four distinct lesions located on anatomically separate body areas. You report the biopsies as:

11106
11107x2
11107-76 X1

You list diagnosis D48.5, neoplasm of uncertain behavior, for each of the biopsies and in the notes specify the distinct location of each biopsy.

Answer: Correct. Separating the excess biopsy MUE unit on its own billing line might prevent a total claim denial. Line billing, as opposed to billing as: 11106, 11107X3, will maximize optimal claim adjudication for a Medicare-insured patient, since each line will be adjudicated individually. (See Example 2.) Since the MUE for incisonal biopsies is 3, the fourth biopsy may be denied and would need to be appealed to the insurer. For correct coding, the additional incisional biopsy billed on the separate line will require appending modifier 76, for Medicare claims. This prevents CPT code 11107 from being viewed as a duplicate claim line and denied on that basis.

Check with your private payers on their policy for the use of modifier 76 when the same exact procedure is reported on a separate line of the same claim. dw
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Technology vs. skin cancer

A new generation of non-invasive tools and apps reduces unnecessary biopsies, promotes self-surveillance.
Improving diagnostic accuracy, avoiding unnecessary biopsies, and engaging consumers in monitoring their own skin are goals that virtually all dermatologists can support. Now a host of emerging technologies are targeting those aspirations and making inroads into dermatologists’ practices and patients’ awareness and habits.

*Dermatology World* spoke with dermatologists who are advancing or using these new technologies, including:

- Reflectance confocal microscopy (RCM) and optical coherence tomography (OCT)
- Molecular tests that use tissue samples taken with adhesive patches
- A smartphone app that supports self-surveillance and melanoma research
**Technology vs. skin cancer**

RCM and OCT

RCM and OCT both provide non-invasive visualization of skin lesions in real time, and both allow longitudinal analysis, but they differ in their depth of penetration, cellular resolution, and field of view. Using a low-power laser beam, RCM “creates an image by detecting backscattered light from illuminated tissue and displaying it on a monitor in high resolution and contrast,” according to a *Cutis* article providing an overview of the technology (2015;95(5):E39-46). RCM provides an en face (horizontal), or cross-sectional view of the tissue, “similar to what you see in dermoscopy, so people think of RCM as a bridge between the dermoscopic view and pathology,” said Orit Markowitz, MD, associate professor of dermatology at Mount Sinai Medical Center and an early adopter of both RCM and OCT. “We can use it to diagnose up to 300 micrometers in depth, and it has the highest cellular clarity of all the non-invasive imaging devices.”

Confocal images of skin areas measuring up to 8 x 8 mm are stitched together into a mosaic, providing information from different layers and facilitating diagnosis. Dr. Markowitz uses RCM, after clinical and dermoscopic examinations, to confirm a suspicion of malignancy or, in some cases, to rule it out. The result is fewer unnecessary biopsies, particularly in cosmetically sensitive areas. If a basal cell carcinoma is diagnosed with RCM, the Mohs surgeon to whom she refers the patient “doesn’t have to start with an already scarred biopsy to the lesion.” If the diagnosis is melanoma, “I can go ahead and excise the lesion in the same visit and not have to do histology, have the patient come back, and then have to cut around the scars that they have.”

Using infrared light, OCT provides a greater depth (up to 2mm) and field of view than RCM, Dr. Markowitz said, but with less cellular clarity. “The deeper you go, the less cellular clarity and the broader the field of view. A lot of what we see is with architecture. As of a few years back, we’ve also been able to add some vessel flow dynamics that help with diagnosis.” The size of the OCT probes allows physicians a view of subtle lesions in areas where the larger probe of the RCM won’t fit, Dr. Markowitz said. In addition, OCT provides her with valuable information for the patient: “If, for example, we know that we have a basal cell proven by RCM, I can get a better idea of how extensive that lesion is, how deep it is, and potentially, what kind of subtype.” She pointed out that there are a variety of OCT devices with different cellular clarity and different depths. “It’s a little bit confusing, I would imagine, because sometimes that’s not clearly categorized within the literature.” Ultimately, the hope is that RCM and OCT will be married into one machine so that physicians can see the lesion on a cellular level and determine the depth all at the same time.

Non-invasive molecular tests

Two proprietary molecular tests from DermTech, Inc., allow dermatologists to obtain a tissue sample by using adhesive patches; the sample is then sent to DermTech for analysis. The Pigmented Lesion Assay (PLA) analyzes RNA extracted from the sample for expression of two genes, PRAME and LINC00518, known to be overexpressed in melanoma. It is designed for use in adult patients with pigmented lesions measuring 5mm or larger and suspicious for melanoma. According to a study published in *Skin Therapy Letter* (2018;23(5): 1-3), the PLA has a higher negative predictive value than histopathology (>99% vs. 83%) and a high sensitivity (91-95%). The PLA is available in all 50 states and in Canada.

An additional test, Nevome™, analyzes DNA from the sample for hotspot mutations of the BRAF, NRAS, and TERT promoter genes. Currently on the market in every state except New York, Nevome is offered as a reflex test to PLA-positive cases to add molecular melanoma risk factor information. The same tissue sample can be used for the PLA and Nevome. DermTech data demonstrate that the combined RNA/DNA test has a sensitivity of 97% and a negative predictive value of >99%. In a study published online in the *Journal of Investigative Dermatology* (doi:10.1016/j.jid.2018.10.041), the authors stated that “expression of LINC and PRAME determined noninvasively via PLA is highly correlated with the presence of somatic mutations in three genes (BRAF non-V600E, NRAS, and TERT) known to be important in melanoma development and progression.”
Smartphone apps
Now in its third release, MoleMapper is one of many smartphone apps designed for patient self-surveillance. What sets it apart: It’s free and open source, it was developed by dermatologists at Oregon Health & Science University, and patients can allow the use of their images for OHSU’s melanoma research. The app guides users through the process of mapping, measuring, and monitoring their moles over time. They can store the images on their devices.

Bringing new tech to residents
Are dermatology residents gaining hands-on experience with the newest non-invasive devices? “In the programs I’m part of, certainly,” remarked Orit Markowitz, MD, in reference to both reflectance confocal microscopy and optical coherence tomography. “I’m teaching residents at both Mount Sinai and SUNY Downstate. We also have a dermatopathologist at Downstate who participated in writing the atlas for confocal microscopy. She’s trying to implement a more formalized program with me to include the pathology residents as well.”

However, not all dermatology residents have that opportunity. Daniel M. Siegel, MD, MS, noted that cost may be a barrier to greater uptake of some technologies among residency programs, just as it is across the field of dermatology. Pointing to the $60,000 price tag for an RCM or an OCT system, he said, “Residency programs, in many cases, are practices that have the same economic constraints as any other practice. They may say if we buy this instrument, will it generate enough revenue?”

Requiring that training in a specific technology be provided in dermatology residency and fellowship programs is a long and painstaking process overseen by the Dermatology Review Committee of the ACGME, currently headed by Erik Stratman, MD, chairman of the department of dermatology at the Marshfield Clinic in Wisconsin. “There are many passionate clinicians, field experts, and others who identify procedures, diagnostic tests, or other new specialty-specific areas of competence that they strongly advocate for incorporation into program requirements,” said Dr. Stratman, who is also president of the American Board of Dermatology. The committee considers a number of factors, he explained, including whether the addition is considered as providing the highest quality of care for patients, or thought to be still emerging; whether it is something most dermatology residency programs are already delivering or can adopt shortly without great added cost; and how stakeholders of dermatology program accreditation (program directors, chairs, faculty, residents) feel about including it as a new requirement.

“When considering technologies and skills to require during residency, the access to the technology and broad acceptance among the education community of the importance of skill development with the technologies are both important to the Review Committee,” he noted.

In a 2014 survey conducted by the AAD among randomly selected practicing U.S. dermatologists, 81% of respondents said they were using dermoscopy in their practice. All dermatologists in the youngest group of respondents said they had received training in dermoscopy. Yet, dermoscopy is only now being specifically named in the latest proposals to be considered for final approval in June, Dr. Stratman said; other non-invasive technologies such as RCM and OCT are not included.
phones to share with health care providers or give their consent to share de-identified images and information with OHSU researchers. “We’re trying to provide a service that allows people to follow the moles that they’re worried about, and let us know what they look like as part of a research project,” said Sancy Leachman, MD, PhD, professor and chair of dermatology at OHSU and director of the melanoma research program at the Knight Cancer Institute. “We want to identify what it is about the moles that makes them concerned, and we’re trying to get people to tell us whether they’ve had something removed or not.”

Achieving standard of care

None of the non-invasive technologies previously discussed is used in the day-to-day practice of most dermatologists. However, as their champions and early adopters continue to publish research supporting their use, and payers follow with reimbursement, further market penetration may be likely — unless the technology is perceived as too costly for the physician or the patient. In a section titled “Emerging Diagnostic Technologies,” the new AAD guidelines for the management of primary cutaneous melanoma (J Am Acad Dermatol. 2019;80[1]:208-250) name RCM, OCT, and adhesive patch “biopsy,” among other technologies, noting that “the uptake of one or more of these technologies will eventually depend on cumulative evidence regarding their effectiveness, clinical utility, cost versus benefit, and competing strategies.” So far, RCM is the only new technology to have been awarded valued CPT codes.

“I don’t practice one day seeing patients without utilizing dermoscopy, RCM, and OCT, so technically for my practice it is standard of care,” said Dr. Markowitz. “However, the percentage of RCM devices within U.S. practices is still relatively low. I do think that with reimbursement in the picture, that will potentially spur more rapid growth and drive it toward becoming standard of care.” RCM received its category I CPT code in 2016. “From my experience in New York at a large academic institution, I’ve had some pretty good reimbursement,” Dr. Markowitz remarked. “Different states probably reimburse better than others, but I think that the more it’s utilized, and the more that insurance companies are aware of it, the better the reimbursement will be as time progresses.” The AAD recently issued a position statement on RCM, voicing support for its use “when clinically appropriate” and recommending that dermatologists and their staff become conversant with federal and state laws relating to billing for RCM, as well as the CPT coding definitions.

Position statement on RCM

To view the Academy’s position statement on RCM, visit www.aad.org/Forms/Policies/ps.aspx.

OCT is behind RCM in terms of adoption and reimbursement. “We’re only 30 years behind Europe on adoption [of both RCM and OCT],” noted former AAD president Daniel M. Siegel, MD, MS, professor of dermatology at SUNY Downstate Medical Center, who uses both devices. Dr. Siegel, who has an ownership stake in clinical and research imaging company Caliber I.D. and serves on its board of directors, said, “One reason for the slow uptake in non-invasive imaging is someone will say, ‘What kind of laser can I buy that will produce the most revenue as quickly as possible?’” The CPT codes for RCM are “fairly valued, and people can make a living with it,” he added. But OCT, with only a category III code for tracking utilization, “is still a few randomized trials away” from getting a category I code that enables reimbursement. Drs. Markowitz and Siegel will be holding a meeting called Autumn Dermatology Conference: Innovations in Aesthetic, Medical and Diagnostic Dermatology, on Nov. 2-4 in New York, where speakers will discuss incorporating new imaging technologies into mainstream dermatology. Learn more at autumndermatology.com.

According to DermTech’s Chief Medical Officer, Burkhard Jansen, MD, the PLA is fully validated with demonstrated utility and run in a state of the art CLIA- and CAP-accredited laboratory. Dr. Siegel, who serves on DermTech’s advisory board, said DermTech’s PLA is “not used enough. It’s very
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sensitive...but a lot of payers are still not paying for it.” Part of this issue, he noted, is the need to send the sample to DermTech for analysis. “I spend two days a week at the VA, and to send something out of there is almost impossible without spending hours of your time to get approved. You may also get pushback from pathologists, who will argue that histopathology is the gold standard.” Dr. Jansen indicates that the adhesive patches collect tissue from the entire pigmented lesion in question, while pathology generally only looks at 1-2% of lesion tissue. With the PLA, “you’re going to get a sample of everything in that ‘soup’ below, so the assay may actually be more sensitive than pathology,” said Dr. Siegel. Despite these obstacles, Dr. Jansen said the PLA has gained more than 600 regular users in the U.S. and provided information to more than 30,000 patients since its pilot launch in 2016. He added that the PLA has CPT codes for the lab assay, the company accepts all insurance except Medicaid, and DermTech offers patient assistance programs, even when both the PLA and Nevome are run. Nevome is new to the market, and Dr. Jansen commented that “feedback to its introduction has also been very positive.”

Engaging consumers
Increasingly, consumers are taking advantage of smartphone technology to monitor and improve their own health and fitness. According to a study of mobile app rankings in dermatology, co-authored by Dr. Markowitz and published as a “Tech Talk” item in Cutis (2018;102(4): 252-256), 11 of 18 patient-targeted dermatology apps (among the top 1,500 medical apps in Apple’s App Store) were designed for self-surveillance. Since the most recent update of MoleMapper in December, nearly 5,000 consumers have installed the app and 10,000 mole measurements have been taken, said Dr. Leachman, for a total of 27,600 installations and 20,500 measurements.

Fortunately for her research team, 25% of those who have installed the app consented to share their data. One repository of that data is the War on Melanoma registry housed behind the OHSU firewall. “We do various studies using the data, and we invite people to participate in surveys that yield a lot of valuable information,” Dr. Leachman said. She also views MoleMapper as a tool for primary care physicians, who may not have the resources in their office to track moles over time, to recommend to their patients. Longer term, she hopes to use the data “to see if we can start to develop algorithms that will effectively and successfully triage people and, ultimately, work with already existing algorithms to create a diagnostic. But that’s way in the future. The real thing now is to figure out how to make these images available for research and get the research done so we know we’re standing on firm ground with respect to the data.”

Dermatologists are cautious about predicting the future of teledermatology and AI apps. “I’m not a big fan of how consumer apps have evolved,” said Dr. Siegel. In the study published in Cutis, Dr. Markowitz wrote that the highest-ranked dermatology app was a teledermatology app that “did not meet the American Telemedicine Association standards for teledermatology apps,” sacrificing accuracy for ease of use. A less frequently used teledermatology app “boasted professionalism and accuracy, but from a user standpoint, it may have been too time-consuming.” Regarding AI, Dr. Siegel noted, “if it’s not FDA cleared you don’t know how good the data is. Some AI systems are wonderful, some are not. There’s a lot of chicanery out there.”

Dr. Markowitz remarked that “to give overconfidence to the user that the AI has already reached the threshold of being helpful...in the U.S. we have to be careful making those assumptions. There are many apps leading consumers to believe that they’re doing things the technology hasn’t quite reached. It’s an important subject, because there’s a lot of enthusiasm about what we can accomplish with very well-written algorithms, and I think we have to be a little careful about what we’re promising consumers — and even if we’re not making promises, what consumers may be assuming. I do think as physicians and diagnosticians, we have to be very careful to make sure that patients are properly consented, meaning that they understand the risk and benefit and that they have an understanding of what is a realistic expectation of the technology that they’re utilizing. We can’t think of these apps as a kind of toy.”
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Reducing the burden of clinical documentation with EHRs

BY SWAPNA BHATIA, MPH, MANAGER, AAD HEALTH TECHNOLOGY & INFORMATICS

Each month Dermatology World tackles issues “in practice” for dermatologists. This month Swapna Bhatia, MPH, the Academy’s health technology & informatics manager, offers tips on an area she commonly receives questions about from members.

It’s no surprise that clinical and administration documentation burden with electronic health records (EHRs) has been on the rise.

Although 78% of dermatology practices reported acquiring an EHR system in the 2017 AAD Practice Profile Survey, the Academy recognizes that there is continued frustration and concern regarding clinical documentation in EHRs. According to that same survey, 76% of group practices agreed that there was too much time spent documenting visits, and 64% agreed that there was too much time spent documenting quality measures. Documenting patients through EHRs was supposed to be simpler and more straightforward than paper-based documentation, but it continues to be more burdensome for physicians.

Top challenges
There are several significant challenges that dermatologists face while using their EHRs, particularly the fast-paced growth in regulations that physicians need to keep up to date on.

Some problems include:

Decrease in physician-patient quality time
With the use of EHRs, quality face-to-face time between a physician and patient has decreased. This could be because of several factors, such as the doctor concentrating on entering medical notes into the EHR or inputting different codes in order to abide by CMS regulations.

Increasing computerization of practice (e.g., clicks to accomplish each task, alert fatigue)
Alert fatigue has increased and is becoming more common than ever, affecting the work of physicians. There are certain alerts that are more significant than others but can become lost within the numerous other messages.

Lack of interoperability
There are many complications impacting attainment of interoperability among dermatologists, including: Lack of free-flow exchange of health information and patient data; no seamless way to require industry-wide interoperability standards across health care facilities; and delays in developing a standardized way to identify patients.

Clinical documentation burden with coding and quality requirements
The current regulatory requirements have made it difficult for dermatologists to have quality time with their patients because they are focusing on implementing EHR vendor upgrades or are trying to meet new reporting deadlines mandated by CMS.

Solutions
There are many solutions that can help alleviate these administrative burdens. The Academy has developed several resources in the AADA Practice Management Center to assist physicians and office staff in alleviating clinical documentation and administrative burden. Content in these areas include health information technology (HIT) assistance for EHR users, burnout resources, and regulation relief resources. Learn more at www.aad.org/practicecenter.

HIT solutions
The HIT page on the Practice Management Center offers tools and tips for practice technology needs for EHR-based users. Topics include: The use of scribes, useful applications, teledermatology, reducing administrative burden, prior authorizations, and more. Visit www.aad.org/practicecenter/managing-a-practice/hit/ehrs.

Training all staff
 Appropriately training all medical staff on using an
EHR is a vital component to understanding the EHR system. There are several advantages that clinical staff would benefit from if proper training were provided that would help them understand the simple components of the EHR system. Training can reflect in higher satisfaction with health information technology and improve clinical practice just by using advanced features provided on the system. Additionally, EHR systems undergo updates constantly. Making sure staff are trained on a continual basis is essential.

**Hiring medical scribes**

Employing certified medical scribes and medical assistants — who have completed training and understand how to navigate EHR systems — can reduce clinical documentation burden and improve the quality of the dermatologist-patient relationship, increase the number of patients seen in a day, and reduce patient wait times. To learn more about hiring scribes, visit [www.aad.org/dw/monthly/2018/june/taking-notes](http://www.aad.org/dw/monthly/2018/june/taking-notes).

**Useful apps**

The Academy’s HIT webpage also provides a breakdown of mobile apps that can assist in reducing the burden of clinical documentation and help run your EHR-based practices more efficiently.


**Addressing physician burnout**

DERM360 is the Academy’s burnout resource page that offers several solutions on addressing physician burnout including overcoming practice challenges, focusing on self-care, and recharging your motivation. The site includes tips on utilizing your EHR more efficiently and how to ease the burden of reporting quality measures in your EHR. Visit [www.aad.org/burnout](http://www.aad.org/burnout) to access these tips and take a burnout assessment.

**Provide relief from regulations**

The Academy has been advocating for relief from burdensome regulations for dermatologists and continues to work to ease these burdens on medical practices. For example, the U.S. Department of Health & Human Services (HHS) recently released two proposed rules that are intended to clarify HIT data exchange requirements and prevent data blocking. The AADA has carefully reviewed those proposals and has provided comments to HHS, to ensure that the rules, when finalized, reduce or at least do not impose additional burdens on physicians, and that they improve the exchange of needed data, thereby improving patient care.

AADA staff and members have also been involved with providing feedback to Congress as part of the Red Tape Relief Project in an effort to find ways to reduce regulatory burdens. Learn more at [https://republicans-waysandmeansforms.house.gov/uploaded-files/red_tape_relief_final_-_v4.pdf](https://republicans-waysandmeansforms.house.gov/uploaded-files/red_tape_relief_final_-_v4.pdf).

Additionally, after much prodding, CMS has recognized that the 1995/1997 E/M documentation guidelines are out-of-date. The 2019 Medicare Physician Fee Schedule Quality Payment Program final rule outlined changes to ease some documentation requirements for office E/M codes. The AADA is also working with the AMA and other specialties to revise these codes to simplify documentation requirements.

For more coding and E/M reimbursement information, visit:
- AADA Coding Resource Center: [www.aad.org/coding](http://www.aad.org/coding)
Workplace violence

BY CLIFFORD WARREN LOBER, MD, JD

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

Question: What is workplace violence?

Answer: Workplace violence describes a wide gamut of unwanted, harmful behaviors ranging from verbal abuse, sexual harassment, hazing, unwanted touching, and stalking, to more overtly violent acts such as rape and murder. The General Duty Clause, Section 5(a)(1), of the Occupational Safety and Health Act of 1970 (OSHA Act) requires that employers provide a workplace that is “free from recognized hazards that are causing or are likely to cause death or serious physical harm.” OSHA has liberally interpreted this statute and defined workplace violence as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site.”

Q: How common is workplace violence?

A: The Occupational Safety and Health Administration (OSHA) reported that from 2002 to 2013 “the rate of serious workplace violence incidents (those requiring days off for an injured worker to recuperate) was more than four times greater in health care than in private industry on average. In fact, health care accounts for nearly as many serious violent injuries as all other industries combined.”

Q: What is my liability as an employer if workplace violence occurs in my office?

A: Penalties for violating the OSHA Act depend upon the intent, severity, and history of the employer’s actions or failure to act to remedy a dangerous situation. Employers who are cited for “a serious violation” may be assessed a penalty of up to $7,000. A “serious violation shall be deemed to exist in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations, or processes which have been adopted or are in use, in such place of employment unless the employer did not, or could not with the exercise of reasonable diligence, know of the presence of the violation.” Violations resulting in death are punishable by fines of up to $10,000 and six months imprisonment.

The individuals who commit violence may be prosecuted under state statutes which prescribe civil and/or criminal penalties for those acts (harassment, assault, battery, murder, etc.).

Q: Who commits workplace violence?

A: Approximately 80% of workplace violence in the health care setting is committed by patients. Relatives and medical staff account for most of the remainder. Abusive or violent behaviors may result from employee dissatisfaction with their jobs, patients or their relatives upset about an office or hospital encounter, or mental illness.

Q: Why is it important to address workplace violence as soon as possible?

A: If lesser forms of violence such as unwanted touching are not addressed, those who commit these acts may interpret inaction as acceptance. They may continue offensive verbal or physical behaviors or commit even more serious forms of violence. Tolerance of verbal abuse, for example, has been shown to be a risk factor for subsequent physical assault.

Whether subtle or overt, workplace abuse and violence contribute to physician and staff dissatisfaction, turnover, and burnout.

Q: What are the signs a fellow employee may become abusive?

Suggested topics

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

See the February 2013 issue of Dermatology World for disclaimers.
**A:** Employees who are increasingly late or absent from work, those who complain excessively about their job or work conditions, and people who have sudden changes in their mood are at increased risk to commit violence. Sometimes a particular life event, such as divorce, increased marital stress, the death of an immediate family member, or even learning of a poor job performance rating may send an employee or patient “over the edge” and cause him or her to become violent.

**Q:** Why is workplace violence underreported or tolerated?

**A:** Unfortunately, physicians and nurses often consider rude, disruptive, or other offensive behaviors acceptable from patients who are ill (physically or mentally) or merely stressed. They incorrectly consider these behaviors “part of the job” and feel that as professionals they need to “deal with it.” They may, alternatively, have little confidence in the reporting system and/or fear retribution from their employer.

**Q:** What should be done to address workplace violence?

**A:** Above all, employers must make it clear that absolutely no form of verbal or physical abuse or violence whatsoever will be tolerated. This policy should be stated when offering an applicant employment, strongly emphasized in your office policy and procedures manual, posted in the employee lounge, and mentioned in staff meetings. Employees should be encouraged to immediately report any instance of patient or fellow employee abuse or violence.

When an employee manifests a significant change in job performance or mood, speaking with that employee promptly and privately may prevent an underlying problem from boiling over. If a patient manifests abusive behavior, your interaction with that patient should be terminated until the abuse is directly addressed and satisfactorily resolved. If the office visit is continued, the physician or nurse should not be alone with the patient for the remainder of the interaction. Finally, if workplace violence or abuse occurs, it must be taken very seriously and not simply excused or overlooked because the employee or patient is “having a bad day.”

**Q:** Are there any other measures I should take?

**A:** Physical measures such as providing adequate lighting and video surveillance in common areas may decrease violence by patients and employees alike. In a medical office, reducing patient waiting times and having adequate staff levels decreases patient and employee stress.

**Q:** I have been told that it is illegal to retaliate against an employee who reports workplace violence. Is this true?

**A:** Section 11(c)(1) of the OSHA Act mandates that “no person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act...” Retaliation against an employee for reporting abuse or violence may also be a violation of state law.

**Q:** Where can I get more information on workplace violence?

**A:** In addition to contacting your attorney, you may wish to contact OSHA at www.osha.gov or (800) 321-6742.

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**Key Points**

1. Workplace violence describes a wide gamut of unwanted, harmful behaviors ranging from verbal abuse, sexual harassment, hazing, unwanted touching, and stalking to more violent acts such as rape and murder.

2. The health care setting accounts for nearly as many serious violent injuries as all other industries combined.

3. Under federal and state laws, employers have a duty to provide a safe environment for their employees and patients.

4. Above all, employers must make it clear that absolutely no form of verbal or physical abuse or violence will be tolerated.

5. If workplace violence or abuse occurs, it must be taken very seriously and not simply excused or overlooked because the employee or patient is “having a bad day.”
Dermatology World covers financial issues for dermatologists in this quarterly column. David B. Snyder, JD, CLU®, is an attorney, author, and financial advisor at the wealth management firm OJM Group.

For a dermatologist who is at least 10 years from retirement, there is likely no asset more valuable than the ability to practice dermatology. Simply stated, the medical license, dermatology certification, and the physical ability to go to work each day and examine and treat patients is a multi-million-dollar asset for most dermatologists.

What if a dermatologist couldn’t get to the medical practice or see patients because of a physical or mental injury or condition lasting months, years, or even decades? The financial consequences of such a situation could be disastrous for a dermatologist and their family. To protect their future income against this risk, dermatologists should implement disability income insurance.

What to look for in a disability income policy: Eight important factors
Disability income insurance is conceptually straightforward: If the insured dermatologist becomes disabled, the policy will pay the disabled doctor. Beyond this basic definition, keep these eight important factors in mind when evaluating a potential policy:

1. **Monthly benefit amount:** Most policies are capped at a benefit amount that equals 60% of income. If you purchase the policy after-tax, then the monthly benefit (if paid) will be income-tax free, so 60% should cover close to a dermatologist’s monthly after-tax expenses. While many dermatologists may find it challenging to reach the 60% with one policy or carrier, experienced agents can often tap into Lloyds of London-type policies to protect higher income physicians.

2. **Elimination period:** This is the period of time that you must be disabled before the insurance company will pay disability benefits. The longer the waiting period before benefits begin, the less your premium will be. You can think of the elimination period as a deductible relative to time — you cover your expenses for the waiting period, then the insurance company steps in from that point forward. If you have adequate sick leave, short-term disability, and/or an emergency fund, choose a policy with a longer waiting period to save money. Though waiting periods can last as long as 730 days, a 90-day waiting period may give you the best coverage for your money.

3. **Time period for benefits:** It often makes sense to get a benefit period of coverage that lasts until age 66/67, at which point Social Security payments will begin.

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**Long-term care planning**

Definition of disability: The definition of disability used for a policy is of the utmost importance. The main categories are Own-occupation, Any-occupation, and Loss of Income. The Own-occupation policies, which pay a benefit if you can’t continue your own occupation (even if you can and do work in another occupation after the disability), are the most comprehensive.

Partial benefits: Will you receive benefits if you can work only part time instead of your previous full-time hours? Unless your policy states that you are entitled to partial benefits, you won’t receive anything unless you are totally unable to work. Also, are Extended Partial Benefits paid if you go back to work and suffer a reduction in income because you cannot keep up the same rigorous schedule you had before you became disabled?

Important Note: Partial benefits may be added as a rider to some policies and should be seriously considered, as only a small percentage of all disabilities are total disabilities.

Non-cancelable or guaranteed renewable? The difference between these two terms is very important. If a policy is non-cancelable, you will pay a fixed premium throughout the contract term, and your premium will not go up for the term of the contract. If it is guaranteed renewable, the policy cannot be cancelled, but your premiums could go up. Ideally you want a policy that is both non-cancelable and guaranteed renewable.

Financial stability of the insurance company: Before buying a policy, check the financial soundness of your insurer. If your insurer goes bankrupt, you may have to shop for a policy later in life, when premiums are more expensive. Standard & Poor’s, A.M. Best Co., Duff and Phelps, and Moody’s all rate insurers.

BOE coverage: If you own your own dermatology practice, coverage for Business Overhead Expense (BOE) should be considered. Whether you have $10,000 or $20,000 of monthly disability benefit, you likely don’t have enough to cover your lost income plus the costs of running the practice. This feature may allow you to cover the costs of the practice (employee costs, rent, etc.) in addition to your personal income.

An experienced insurance advisor can assist you in evaluating your options and selecting a policy that fits your needs and long-term financial goals.
Special focus: Employed dermatologists
Dermatologists employed by hospitals or medical practices should beware of group disability insurance available through their employers. Often, group insurance is not occupation specific, has short benefit periods, does not have a partial or inflation protection rider, and can be cancelled at any time. While that is not the case with all employers, group insurance is generally not adequate for a dermatologist and it should be supplemented with personal coverage.

Special focus: Young dermatologists
Many young dermatologists look at their financial situation and don’t think of themselves as owning any significant assets, never mind being “wealthy.” This may be understandable, as most have lower incomes while in their training years and, even when making higher incomes in practice, are often saddled with significant student loans. Nonetheless, the simple fact is that millennial dermatologists all have a valuable asset that they must recognize and protect — their ability to practice medicine in their specialty and the potential future income this will generate.

In the financial world, there is the concept of “present value of future cash streams.” This concept is ubiquitously applied to valuation of stocks, bonds, loans, and other income sources. Essentially, assuming some interest rate, one can calculate the present value of a stream of future cash flows. If we apply that concept to a young dermatologist’s lifetime income stream, it quickly becomes apparent that many millennial dermatologists are “present value” millionaires and should plan accordingly.

Conclusion
A dermatologist’s ability to practice in their specialty is an extremely valuable asset and the possibility of becoming disabled puts the doctor’s future income at serious risk. It is essential for young dermatologists to secure disability income insurance early in their careers, and for all physicians to regularly review their disability insurance policies to ensure that they are maintaining adequate coverage for the most cost-effective premiums. The author welcomes your questions.

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BREAKING THROUGH

Advances in disease pathogenesis and treatments offer new promise for patients with connective tissue disease.
There are more than 200 disorders that impact connective tissue, and because some of these disorders predominantly affect the skin, or have skin-related implications, dermatologists are faced with diagnosing and treating a wide variety of connective tissue diseases (CTDs).

Managing and treating CTDs can be challenging as these chronic inflammatory disorders are associated with complex genetic and environmental interplay. Additionally, there is a dearth of therapeutic options for patients. However, that may be changing as a surge of clinical breakthroughs may offer new promise.

*Dermatology World* takes a look at what’s new in the understanding of, and treatments for:

- **Lupus erythematosus**
- **Dermatomyositis (DM)**
- **Scleroderma (systemic sclerosis) >>**
**Lupus erythematosus**

People with lupus look different both molecularly and clinically. Lupus has a really broad spectrum with a lot of heterogeneity, said Victoria Werth, MD, professor of dermatology at the University of Pennsylvania, chief of dermatology at the Corporal Michael J. Crescenz VA Hospital (Philadelphia), and director of the autoimmune skin disease center at Penn. “With cutaneous lupus erythematosus (CLE) patients at one end and systemic lupus erythematosus (SLE) patients without skin at the other end, the pathogenesis is not going to be the same for every patient.” Indeed, there are more than 50 genes that have been found to contribute to the disease, and likely, having more than one gene polymorphism, in some situations, may change the character of the disease, she said. There is a whole range of genetic variations within the disease that can have different triggers, adding to the complexity of the disease, including genetic or environmental components, Dr. Werth said.

**The role of type 1 interferon**

Lisa Pappas-Taffer, MD, medical director at Penn Dermatology at Bucks County, is excited by the progression of lupus research. “It’s moving into the world of molecularly targeted therapies. For a long time, we really didn’t understand — and we still don’t totally understand — what causes lupus, but we know the type 1 interferon (IFN-1) pathway plays a major role in both systemic lupus and cutaneous lupus. Most SLE patients show a sustained activation of the IFN-1 system which reflects an overexpression of IFN-1-regulated genes” (*Clin Exp Rheumatol*. 2018;36(5):763-777).

Recent trials have specifically targeted the interferon pathway with positive results. Lupus researchers are following in the steps of psoriasis research, in which you identify a pathway and then aim at that pathway or at those targets in different ways, Dr. Pappas-Taffer explained. A key question for Dr. Pappas-Taffer and other researchers is figuring out what stimulates the interferon pathway. “We don’t really know,” she said. Some patients are genetically predisposed, while environmental triggers like sunlight or certain medications can induce skin lesions or flares.

Dr. Werth, who conducts clinical and translational research for both lupus and dermatomyositis (DM), has been studying skin cells in lupus patients, trying to understand what types of patients respond to various treatments. In a recent study published in the *Journal of Investigative Dermatology*, Dr. Werth and her colleagues explored how hydroxychloroquine (HCQ) and quinacrine (QC) have different mechanisms of action. HCQ responders have higher type 1 interferon in their skin and lower TNF-α, while QC responders, those requiring both HCQ and QC together, have higher TNF in their skin and lower type 1 interferons. Dr. Werth and her team concluded that an increased myeloid dendritic cell population with higher TNF alpha expression might contribute to the ineffectiveness of HCQ and a better response to QC (2019. 139(2):324-332).

HCQ works for about 50% of patients with cutaneous lupus erythematosus (CLE), but there are HCQ-refractory patients who benefit from the addition of QC. “They are both antimalarials so we usually lump them together, but they work very differently, so it’s important that we have access to both of them,” Dr. Pappas said, referencing the fact that compounded QC can be difficult to obtain.

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**In-office preparations**


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A large trial is ongoing of a lenalidomide derivative (CC-220) for patients who have SLE. “The patients in the trial have refractory CLE, and we’re really interested in trying to understand the pathophysiologic basis for the heterogeneity of responses in CLE patients — which drugs are going to work for them, and what are some of the mechanisms for that response,” Dr. Werth said. Lenalidomide has shown to be an effective treatment option for cutaneous lupus, but it’s difficult to get because it’s priced in the oncology market, Dr. Pappas-Taffer added.

**Biologics**

A primary concern for physicians treating lupus patients — and a concern driving the swell of new research — is the lack of therapeutic options. Belimumab, approved in 2011, is the only FDA-approved biologic to treat SLE. While the drug shows improvement in some patients, it hasn’t been formally studied in skin, said Dr. Werth. “We really don’t know that much about the effect in CLE,” she said. Other B-cell targeted therapies failed to show an effect in large phase 3 trials despite early promising results (*Curr Rheumatol Rep*. 2017(19): 10).

Despite the modest success of belimumab, it has ushered in a new class of targeted drugs for lupus. Numerous other trials are underway for biologics that have the potential to benefit a larger subset of lupus patients. Dr. Werth was involved in a recently published phase 2 study in the *Journal of Clinical Investigation* in which they explored whether a new humanized monoclonal antibody (BILB0539) has an impact on patients with active cutaneous disease.
BIIB059 binds to blood DC antigen 2 (BDCA2), a pDC-specific receptor that inhibits the production of Type 1 IFN and other inflammatory mediators when ligated. Importantly, the study showed improvement not only of systemic lupus, but also cutaneous lupus using the Cutaneous Lupus Erythematosus Disease Area and Severity Index (CLASI), Dr. Pappas-Taffer said. Targeting pDCs may provide a new area of exploration in treating SLE patients with cutaneous involvement.

**JAK inhibitors**

In 2018, the FDA granted baricitinib, a JAK inhibitor, fast-track status for the treatment of rheumatoid arthritis. Wallace, et al hypothesized that baricitinib might have a therapeutic benefit in patients with SLE, and so they performed a phase 2 study looking at combined endpoints of skin and joints. Improvements were seen primarily in the joints more than the skin, Dr. Werth said (*Lancet*. 2018; 392: 222-31). At week 24, there was a greater reduction in the placebo group than the 4 mg baricitinib group in the combined skin and joint endpoint. While the baricitinib did not show positive results for CLE, a larger phase 3 trial that hopefully includes more severe skin disease is being conducted. Further elucidation of these pathways may bring novel JAK inhibitors to the forefront of dermatologic therapy.

**The challenges**

A challenge in lupus research has been moving from phase 2 to phase 3 trials because the drugs being tested don’t make the disease go away, Dr. Werth said. “It’s not like psoriasis and eczema, where therapies are good enough to clear skin disease, but we’re still being held to that standard. It’s hard to do studies in the skin if we don’t have the ability to use the CLASI as a more sensitive endpoint that can show meaningful improvement in the skin,” she said. The key is to learn how to design those phase 3 trials in smart ways that use the right patients and the right sites and really allow for interpretable results, Dr. Werth added.

Despite the proliferation of clinical trials for potential lupus treatments, many of them have failed, said Dr. Werth. “There have been huge trials looking at B-cell drugs, like rituximab, and different drugs like that, and they haven’t been quite as helpful as one might expect.” Within any group of CLE or SLE patients, there are so many variations, many new or emerging therapies are not one size fits all. What may be life-changing for one patient may have little to no effect on others, she said. There is a need to determine biomarkers that may predict which patient may benefit from a specific therapy.

“There’s really a lot of room for finding more effective therapies, and we hope to be able to do that in the near future,” Dr. Werth said. “What we need are label-approved drugs and also more effective and safer drugs for these patients.”

**Dermatomyositis**

Over the past 10 years or so, the most exciting clinical development in dermatomyositis (DM) research has been phenotypic groupings based on myositis-specific antibodies, Dr. Pappas-Taffer said. “In the past, physicians would suspect dermatomyositis, and they would check antinuclear antibodies (ANAs), which we know are not diagnostically very sensitive,” she said. However, there are a lot of DM patients who do not have any myositis-specific antibodies, even though quite a few have been discovered. It is important for physicians to order a comprehensive myositis panel for patients because this may change their prognosis, Dr. Pappas-Taffer said. A negative test doesn’t mean that the patient doesn’t have dermatomyositis. However, a positive result gives physicians a lot of information to act on, she said.

**Myositis-specific antibodies**

For example, MDA5 is an antibody that is associated with dermato-pulmonary syndrome. On the skin you see ulcerations and you have non-scarring alopecia, but you don’t have any muscle involvement, explained Dr. Pappas-Taffer. “However, you do have severe interstitial lung disease, and we have to act fast because the lungs can crash really quickly. If we know somebody has this antibody we do more frequent lung screenings and we are more aggressive with monitoring and treatment,” she said.

NXP2 and TIF1-γ antibodies are also receiving attention for their ability to stratify patients, said Alisa Femia, MD, director of inpatient dermatology, director of autoimmune connective tissue disease, and assistant professor of dermatology at New York University Langone Health. Both of these antibodies are associated with increased cancer risk compared to a dermatomyositis patient without these antibodies, Dr. Pappas-Taffer said. All dermatomyositis patients have an elevated cancer risk, but patients with these antibodies are specifically higher. “Clinically, NXP2 looks totally different than the TIF1-γ. An NXP2 has really bad muscle disease, calcinosis, and dysphagia, and are typically male, and the TIF1-γ often has very recalcitrant, severe skin involvement.” Being able to classify patients based on specific antibodies can guide physicians in how to better manage patients moving forward.

**The role of interferon**

Like lupus, the role of interferon has provided new insights into understanding the pathogenesis of the disease, and in particular, interferon-β has gained attention. Tofacitinib is a medication that impacts
interferon, and the use of this medication in cutaneous dermatomyositis has shown benefit in refractory cases. Dr. Femia is also involved with a drug in clinical trials developed specifically to treat cutaneous DM.

**Lenabasum**

One of the more promising treatments in the pipeline for multiple diseases is lenabasum, an oral small-molecule medication that selectively binds as an agonist to the cannabinoid receptor type 2 (CB2). It is considered a “first of its kind” treatment because it targets the signaling system that cells use to resolve inflammation without suppressing the immune system as a whole. The drug may improve itch and skin disease in DM patients, and also appears to be well tolerated, Dr. Femia said.

Lenabasum successfully achieved the primary objective of a phase 2 study conducted by Dr. Werth at Penn, in which improvement in the CDASI was 9.3 points for the treatment at the end of the study versus a reduction of 3.7 points for the placebo treatment. The drug may ultimately be a good adjunctive therapy since many patients with DM require combination therapy, Dr. Femia added. Lenabasum is currently in a phase 3 trial for both DM and scleroderma, and in a phase 2 trial for SLE.

**JAK inhibitors**

JAK inhibitors have certainly taken the dermatologic world by storm with demonstrated efficacy in treating a variety of dermatologic conditions. Now they are being explored for the treatment of DM as well, prompted by a serendipitous discovery in which a patient treated with ruxolitinib for myelofibrosis also experienced improvement in their DM (N Engl J Med. 2014 Dec 25;371(26):2357–8). Inhibiting the JAK-STAT pathway has been reported to mitigate IFN signaling, which is thought to contribute to disease pathogenesis in DM.

Dr. Femia contributed to a *JAMA Dermatology* research letter suggesting that tofacitinib may be a good alternative therapy for refractory DM (2016;152(8):944-945). While only three refractory patients were part of the study, CDASI activity scores decreased in all three patients with a mean improvement of 12 points after about nine months of treatment. Other researchers have replicated the positive results of using tofacitinib to treat DM. Another small cohort study found that four refractory cutaneous DM patients all responded well to tofacitinib with significant improvement in cutaneous manifestations (Rheumatology. 2019. Jan. 3. doi: 10.1093/rheumatology/key366. [Epub ahead of print]).

The CDASI has been validated and used in several phase 2 and ongoing phase 3 trials for DM. Studies show improvement in the CDASI correlates with meaningful improvement of QoL for patients.

**Scleroderma**

Scleroderma has proven to be an exceptionally difficult disease to manage — carrying the highest mortality of all the rheumatic diseases, said John Varga, MD, director of Northwestern’s Scleroderma Program. “It’s not an easily classifiable disease in the way that lupus is a typical autoimmune disease.” While the disease clearly involves autoimmunity, there is also scar formation and fibrosis and an inability to repair tissue damage. “And then there’s also a lot of vascular problems like ulcers and pulmonary hypertension. It’s never really clear how these different things all come together, or what we should be treating,” Dr. Varga said.

The cause of the disease is unknown, however, there is a known genetic component since having a family member with scleroderma is one of the highest risk factors, explained Eliza PS Tsou, PhD, Edward T. and Ellen K. Dryer Early Career Professor of Rheumatology and research assistant professor at the University of Michigan. But there are other mechanisms involved.

It is well documented that exposure to environmental factors, such as solvents, viral infection, and certain drugs can cause scleroderma. “These external influences affect epigenetics, which refers to mechanisms that turn certain genes on or off without altering the DNA sequence. Unlike genetics, which is static, epigenetics is dynamic and reversible, therefore, optimal for therapeutic targeting,” Dr. Tsou said.

**Epigenetics and precision medicine**

Over the past decade, epigenetic research in scleroderma has focused primarily on the fibrosis aspect of the disease. Dr. Tsou’s research focuses on epigenetic changes in the blood vessels in scleroderma patients. As blood vessel complications are the first sign of symptoms in scleroderma, studying cells isolated from blood vessels will help us understand how the disease is initiated, and potentially stop the disease from progressing into the later fibrotic stage, she explained. “Because of the difficulty in isolating these cells, the vascular biology of this disease is a largely unexplored territory, which makes our work critical in understanding the underlying cause of this devastating disease.”

Since no drug has been clearly proven to stop or reverse the key manifestations of skin thickening and tissue fibrosis, physicians are faced with managing a disease with few treatment options. Dr. Varga is a strong proponent of precision medicine — or using an individual’s genetic characteristics, lifestyle, and health history to customize treatment. “Some drugs treat the immunity, some drugs treat the vascular, but there’s no agreement on which one of these we should really be focusing on. Scientists believe it varies person to person,” Dr. Varga explained. “Some people really need immunomodulatory treatment, while some people
need more anti-fibrotics.” With the advances in next-generation sequencing, scientists can examine gene expression at the single-cell level in the skin, identifying new targets and new cell clusters, Dr. Tsou added. “Gene expression signatures may play a significant role in future treatment options for scleroderma patients.”

In the pipeline
While the amount of scleroderma research has exploded in recent years, many of the drugs in clinical trials have shown modest efficacy. “It’s not that they’re completely useless, but their efficacy is relatively modest and variable,” Dr. Varga said. There is a wealth of fascinating information coming from genetics and biomarker initiatives that will help researchers design better — more precise — clinical trials, he said.

There is, however, a study that Dr. Varga is excited about that is exploring the efficacy of nintedanib, a tyrosine kinase inhibitor, in treating scleroderma. In early 2018, the FDA granted Fast Track designation to the drug for the treatment of systemic sclerosis with associated interstitial lung disease. The Safety and Efficacy of Nintedanib in Systemic Sclerosis (SENSCIS™) trial — in phase 3 — is the largest ever done in scleroderma research, enrolling more than 520 patients from 32 countries. While the results of the trial are still pending, it is possible that nintedanib could become the first drug to be approved by the FDA for the treatment of scleroderma, Dr. Varga said.

Additionally, lenabasum is in a phase 3 trial for scleroderma that is expected to be completed in March 2020. In a phase 2 extension trial, 75% of patients showed meaningful skin improvements with lenabasum, defined as achieving a modified Rodnan Skin Score (mRSS) of more than five points. One-third of the participants ended the study with an mRSS below 10. Researchers also saw improvements in patients’ other skin symptoms, the amount of disability they reported, and their ability to function. According to the manufacturer’s website, the drug may be available to treat scleroderma as soon as 2021.

Emerging research
Dr. Tsou is on the frontline of epigenetic research where she works closely with University of Michigan colleagues Dinesh Khanna, MD, Frederick G.L. Huetwell professor and director of the Scleroderma Program, and Amr Sawalha, MD, professor and director of the division of rheumatology at UPMC Children’s Hospital of Pittsburgh and director of the University of Pittsburgh Lupus Center of Excellence. They’ve focused their work on histone changes, one type of epigenetic mechanism, in scleroderma. “We found that endothelial cells from scleroderma patients have higher levels of histone deacetylase 5 (HDAC5), which is responsible for inhibiting angiogenesis in these cells. Using an unbiased next-generation sequencing approach, we were able to identify several HDAC5-target genes that play functional roles in angiogenesis,” Dr. Tsou said (https://onlinelibrary.wiley.com/doi/full/10.1002/art.39828).

Their recent work focused on EZH2, a histone methyltransferase. Studying dermal fibroblasts and endothelial cells from patient biopsies, they showed that this enzyme is pro-fibrotic and anti-angiogenic in scleroderma. “Inhibitors of EZH2 can normalize scleroderma fibroblasts and restore angiogenesis in scleroderma endothelial cells.” Most of the current drugs for scleroderma treat one aspect of the disease, but Dr. Tsou and her colleagues’ research suggests that targeting EZH2 can tackle fibrosis while improving blood vessel function at the same time (https://doi.org/10.1073/pnas.1811061116). EZH2 inhibitors are in high demand in oncology, so some EZH2 inhibitors are already in clinical trials in cancer. “We are hoping that our results provide a mechanistic foundation for repurposing these so-called ‘epi-drugs’ to be used in scleroderma,” she said, which would significantly shorten the time from bench to bedside.

On a cellular level, there have been trials using stem cell transplantation and bone marrow transplantation. A study in the New England Journal of Medicine found that scleroderma can be treated effectively by stem cell transplant (doi:10.1056/NEJMoar1703327). Compared with the standard of care treatment cyclophosphamide, transplantation offered significantly greater long-term benefits, but also carried short-term risks, such as infections and low blood cell counts. Participants who received transplants were much less likely to die from disease progression compared to those who received cyclophosphamide.

There have been a few small clinical trials using bone marrow transplantation, which have shown pretty impressive results and are becoming more studied, said Dr. Varga. Because a bone marrow transplant is a drastic, high-risk procedure, it is not practical for most patients. “We’re trying to understand if it works — and are there other ways to get the same result without such a drastic measure?” he said.

Dr. Varga believes the focus should move toward designing more effective clinical trials. It may be that trials showing a particular drug isn’t working well may not be including the right kind of patients, he said, returning to the idea of how precision medicine is key to treating a disease like scleroderma.
“When you think about yourself, skip the ‘only,’ as in ‘I’m only a surgeon’ or ‘I’m only a dermatologist.’ Think about what needs to be done and how you can make it happen.” For those of you who attended the Annual Meeting in Washington, D.C., this year, you were likely inspired, as I was, by these words spoken by Boris Lushniak, MD, MPH, professor and dean of the University of Maryland School of Public Health, during the plenary session when he received the 2019 Clarence S. Livingood, MD, Memorial Award and Lectureship. Dr. Lushniak discussed the importance of service and leadership during his talk — two vital activities that I believe dermatologists are well-equipped to undertake.

I spoke to many Academy members at this year’s Annual Meeting about the joy of practicing dermatology, and I know I am not alone when I say that choosing dermatology as my career was one of the best decisions of my life. Because dermatology has given me so much professional fulfillment, I feel compelled to give back by engaging with my community and our specialty. Fortunately, our Academy offers many opportunities for you to get involved.

Members can choose from several patient and public outreach programs to support with their time and/or money, such as Camp Discovery or the SPOTme™ Skin Cancer Screening. Last year, I participated in an Adopt-a-Shade dedication ceremony in St. Louis, where I was incredibly inspired by the work of AAD member M. Laurin Council, MD. She saw a tremendous need for shade at her children’s school, so she helped the school’s teachers develop a sun-safety curriculum and made a generous donation to the AAD to make a shade structure possible. Her efforts not only provided a sun-safe area for children to play, but she also helped raise skin cancer awareness throughout her community. Read more about the Academy’s Adopt-a-Shade program at www.aad.org/support-aad/what-you-can-support/adopt-a-shade, and check out other inspiring stories about giving back in the Academy’s philanthropic magazine, Aspire, at www.aad.org/members/publications/aspire.

Community events aside, you can also make an impact on your specialty by participating in the Academy’s Leadership Institute initiative that provides training, mentoring, and networking opportunities to help dermatologists develop leadership skills to make them successful in their careers, the AAD, organized medicine, and in life. It’s up to those of us who have been practicing for several years or decades, to guide the next generation of dermatologists. Learn more about the Leadership Institute at www.aad.org/members/leadership-institute.

Finally, let’s not forget about advocacy! In order to make a dent in Washington, D.C., and in our state houses, we need to be involved in grassroots advocacy. When the Academy calls on you to contribute your voice and your financial support, please heed the call. It’s easier than you think. Check out the Academy’s Advocacy Action Center at https://takeaction.aad.org/home.aspx.

I know many of us are feeling burnt out by EHRs, paperwork, regulatory requirements, and constant battles with insurance companies. However, if we work together, we can ensure the success of our specialty, a more fulfilling career for ourselves, and most importantly, a brighter future for our patients. dw
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Patients are asking dermatologists for minimally invasive procedures because they trust them to help them look their best.Injectables, in particular, are a popular choice. Americans spent $1.2 billion on injectable procedures in 2017.1 Adding medical aesthetic procedures can help you build loyalty with existing patients, and help you earn more referrals from their friends and family.

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The decision to purchase minimally invasive procedures takes on average nearly 4 months.2 And, 82% of CareCredit cardholders surveyed said they would not move forward with a minimally invasive procedure if they couldn’t use credit.2 Whether they see financing on your website or in your practice, CareCredit can help patients accelerate their decision-making process.

Give patients a way to pay for both medical and aesthetic dermatology care.

Many providers who accept CareCredit see the difference it makes in helping patients pay for dermatology care they need, and elective aesthetic procedures they want. For CareCredit cardholders considering a minimally invasive procedure, only one-third said they were satisfied with payment choices that were available to them.2 Letting patients know they can also use their card to pay for medical aesthetic treatments and procedures could help them move forward with your recommendation.

With CareCredit, patients can choose a special financing option* and pay over time for procedures they want. And, once approved, they can use their card again and again* to maintain their look without having to reapply. When they have a convenient way to pay, more patients can get the beautiful look they want.

Look for our next article to learn how CareCredit can help patients pay for skin care procedures and products.

Join the CareCredit provider network at no cost today.

Visit carecredit.com/dw or call 855-244-3973.

2CareCredit Path to Purchase – Cosmetic, 2018.
*Subject to credit approval. Minimum monthly payments required. See carecredit.com for details.
What is the Academy doing to educate members about appropriate coding and billing?

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.

The Academy offers a wealth of up-to-date resources to help educate members about appropriate coding and billing.

NEW: AADA Coding Resource Center

The new AADA Coding Resource Center offers the following resources for Academy members:

- **Coding essentials:** Read in-depth information on ICD-10-CM diagnosis codes, E/M coding, surgical and procedure codes, modifiers, and audits.

- **Coding resources:** Ask a coder in the Coding Community, download coding tip sheets, peruse a coding quiz library, and check out a coding video library.

Check out the new AADA Coding Resource Center at www.aad.org/coding-resource-center.

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**Academy position statement**

Read more on the Academy’s position on indoor tanning at www.aad.org/indoor-tanning-ps.

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**Academy publications**

- **Dermatology World Cracking the Code column:** Alex Miller, MD, Academy representative on the AMA-CPT Advisory Committee, offers a tutorial and interactive quizzes on the most pressing coding and billing issues each month in Dermatology World. Access archives of Cracking the Code at www.aad.org/dw.
**DW Academy Insider Practice Management section:** Get the latest news on Academy coding and billing resources in this weekly e-newsletter, delivered to your inbox every Thursday. (See sidebar for more on how to subscribe to this member benefit.)

**Derm Coding Consult:** This newsletter provides Academy members with the latest information about accurate diagnostic and procedural coding, as well as Medicare reimbursement issues in dermatology. Learn more at [www.aad.org/members/publications/derm-coding-consult](http://www.aad.org/members/publications/derm-coding-consult).

### Other Academy resources

- **2019 Coding Webinar All-Access Pass:** Get the latest 2019 updates on coding, reimbursement, and documentation issues affecting dermatology. Learn more at [https://store.aad.org/products/12158](https://store.aad.org/products/12158).

- **Coding and billing manuals, documentation essentials, and more!** Learn more about these products and resources at [https://store.aad.org/Search?search=coding+and+billing](https://store.aad.org/Search?search=coding+and+billing).
I’m confused about the new biopsy codes. Does the Academy offer any resources to help?

Absolutely. The Academy recently published an update to the online Practice Management Center on aad.org, featuring:

- Quick guides
- Downloadable reference tools
- Interactive quizzes


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!

Get more coding tips

Still unsure? Dermatology World recently published a comprehensive, three-part series on the new biopsy codes as part of Alex Miller, MD’s monthly “Cracking the Code” column. Access the November 2018, December 2018, and January 2019 editions through the DW online archives at www.aad.org/dw.

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**

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Q Does your institution or practice provide child care? If so, what does it entail?

“ Our practice emphasizes total wellness, including that of our providers. While we do not currently offer childcare, we definitely offer our employees support with flexible time to handle unexpected childcare and family issues. Everyone cross-trains; it’s a real team environment.”

—Shani Francis, MD, Gurnee, Ill.

“ For the first five years after residency, my employers did not have childcare and I needed two nannies plus a mother-in-law ‘on call’ to ensure coverage for my four children. My business partner and I opened our own practice over 15 years ago. While we do not have an official childcare institution in our practice, we do allow employees to bring their children in to our practice if the child is sick or off from school, or if there is a temporary child care issue. We have sleeping bags, pillows, and toys available for the sick kids, and the healthy ones sometimes help out around the office.”

—Diane Orlinsky, MD, Towson, Md.

“I previously worked in two dermatology sections at academic institutions in Philadelphia and San Antonio, and neither provided any childcare services. Currently I am in private practice and set up early childcare in-house with a nanny, until I can transition to neighboring learning centers for toddlers.”

—Adaobi Nwaneshiudu Obasi, MD, PhD, Laredo, Texas

“ Coordinating childcare can be challenging during dermatology training. I had my first child during residency, and now, as I finish up my one-year cosmetic fellowship, I am pregnant with my second child. So far, neither of my training institutions have offered childcare services. I have been blessed to have my amazing mother help me with childcare while I complete my training. I could not do this without her!”

—Amanda Suggs, MD, Houston
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Registration, housing for the 2019 AAD Summer Meeting open

Registration and housing for the 2019 AAD Summer Meeting, July 25-28, in New York at the New York Hilton Midtown hotel, is available online at www.aad.org/summer19. Housing reservations at the New York Hilton Midtown hotel and the London NYC hotel must be made online in conjunction with meeting registration to receive the discounted housing rate. See the AAD registration website for hotel deadlines, cancellation, and meeting policies. Experient is the official AAD Housing Provider. You should only make your housing reservations through the AAD Meeting website. More information about the 2019 AAD Summer Meeting is available on the Academy website and in the Advance Program Announcement, which was mailed in late April.

Make an impact. When you register for the 2019 AAD Summer Meeting, you can also make a donation and join in helping us change lives through two vital AAD programs.

AAD Resident Education Grants help to ensure that more than 1,300 dermatology residents are able to experience the AAD meetings 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.

Camp Discovery gives children with chronic skin conditions a life-changing summer camp experience, where they can build self-esteem and learn they are not alone in their daily struggles.

Your donation will positively impact patients, the public, and our communities. Make your donation as you complete your online registration for the meeting. – TIM MOSES

2020 committee appointment application now open

Members are essential to every association and the American Academy of Dermatology and AAD Association are no different. The Academy is one of the most influential medical organizations in the world because its members are willing to offer their time and energy to activities to further advance the Academy’s strategic framework.

Every year, hundreds of dermatologists serve the Academy through its organizational governance structure and through other service opportunities. The Appointment Selection Committee, chaired by Bruce H. Thiers, MD, FAAD, has begun accepting applications to fill 2020 open appointments.

The 2020 online appointment application is available at www.aad.org/applications/cctf.

Applications must be submitted by June 30, 2019. Members who are selected to serve will be contacted in the winter of 2019. Letters of recommendation are strongly encouraged, however not required.

Information outlining the specific committees and task forces, committee member responsibilities, and other opportunities, is available in the Governance Handbook at www.aad.org/about/cctf/cctf-resources.

For more information, contact Christine Siwik, the Academy’s governance manager, at (847) 240-1061 or csiwik@aad.org. – CHRISTINE SIWIK
OBITUARIES

JON GARRY BEIDLER, MD, of Chambersburg, Pennsylvania, Dec. 30, 2018, at age 82.

THOMAS ONG CHUA, MD, of Aurora, Illinois, Oct. 16, 2018, at age 77.

THEODORE A. DANN, MD, of Fair Oaks, California, Aug. 21, 2017, at age 87.

KENNETH J. DEMPSEY, MD, of Sikeston, Missouri, Nov. 28, 2012, at age 84.

LOREN E. GOLITZ, MD, of Denver, March 8, 2019, at age 77.

JOHN E. LEDONNE, MD, of Lunenburg, Massachusetts, Feb. 28, 2018, at age 95.

LAWRENCE HARVEY LEIMAN, MD, of Encino, California, Aug. 4, 2018, at age 82.

ARNE S. LEVINSON, MD, of Westport, Connecticut. Trained in dermatology at Mt. Sinai Hospital.

THOMAS MEHREL, MD, of Miami Beach, Florida, Feb. 11, 2019, at age 63.


THOMAS MICHAEL O’NEILL, MD, of Overland Park, Kansas, July 15, 2016, at age 77.

YOLANDA ORTIZ, MD, of Mexico City, Jan. 15, 2019, at age 85.

ARNOLD L. SCHROETER, MD, of Rochester, Minnesota, Feb. 14, 2019, at age 83.

MARCY L. STREET, MD, of Okemos, Michigan, March 22, 2019, at age 59.

WALLACE STUART, MD, of St. Louis, Feb. 27, 2018, at age 83.

JESSE RAYMOND THOMAS III, MD, of Carrollton, Texas, Jan. 12, 2019, at age 68.

EVELYN E. VANDERVEEN, MD, of Grand Rapids, Michigan, Oct. 5, 2018, at age 69.

THELMA GOLUB WARSHAW, MD, of Maplewood, New Jersey, May 26, 2018, at age 94.

More detailed obituary information, researched and written by Jerry Graff, MD, is available at www.aad.org/dw.

Obituaries are published in Dermatology World after information is submitted to the AAD. Information on member obituaries should be submitted in writing to Member Resource Center, AAD Member Services Dept., P.O. Box 1968, Des Plaines, IL, 60017-1968, via fax at (847) 330-0050, or via email at mrc@aad.org. Jerry Graff, MD, assembles additional information for each obituary on behalf of DW.
Academy offers International Society Annual Meeting travel grants

Travel abroad! The AAD offers grants to dermatology residents, fellows, or young dermatologists (within five years of completing residency) from the United States and Canada for travel to dermatology meetings in Asia, Europe, and Latin America. The program offers participants an opportunity to meet foreign colleagues and establish long-lasting professional relationships.

Criteria for applicants:

- Maximum of two applicants per residency program
- One applicant per residency program per international meeting
- One year of training or more must be completed by the time of the meeting
- Individuals may receive an International Society Travel Grant only once during their careers
- Residency program directors must provide applicants with a signed letter of recommendation (PDF preferred format), to be attached to online applications, which indicates approval of time off for society meetings
- Prior to applying, all potential scheduling conflicts must be resolved to avoid taking the opportunity away from other applicants
- No deferrals permitted. Eligible applicants may reapply the following year if unable to accept scholarship
- Through mutual arrangements with several international dermatological societies, several travel grants are available for U.S. and Canadian residents, fellows, or young dermatologists (within five years of completing residency) to attend these societies’ meetings. Each scholarship program has different requirements and provisions.

Each program has different requirements. Learn more at www.aad.org/members/awards-grants-and-scholarships/international-society-meeting-travel-grant. Applications open June 2019. – KARI WEBB
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Aon .............................................................................. Insurance ................................................................................................39
CareCredit ............................................................... Advertorial ...............................................................................................47
CompuLink ............................................................. EHR ..........................................................................................................57
Hill Laboratories ..................................................... Hill90D .....................................................................................................51
Johnson & Johnson ................................................ Aveeno .......................................................................................................5
Midmark ................................................................. Corporate ................................................................................................23
Modernizing Medicine ............................................ EHR ............................................................................................................3
Outcome Health ...................................................... Corporate ................................................................................................53
Nextech ......................................................... Corporate ................................................................................................31
Visual DX ........................................................... Corporate ....................................................................................................

Recruitment Advertising
Navaderm Partners ..................................................................................................................................................58
Sutter Health ................................................................................................................................................................58
Western Dermatology Consultants ................................................................................................................................58

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NEW JERSEY
Part time derm practice Jersey Shore area for sale. Call (908) 309-9275.
Despite concerns, dermatologists retain primary control of their practices

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Amid ongoing debate about the evolution of dermatology practice settings and the role of equity-backing in the specialty, new AAD survey data indicates that dermatologists have maintained both primary ownership and management of their practices. According to the Academy’s recent Life in Practice survey, more than half of dermatologists have an ownership stake in their practice.

Management of dermatology practices follows a similar trend, with dermatologists either managing (or serving as at least one of the managers) in more than 60% of practices. dw

Dermatology practice ownership

Dermatologist Owners 57%
Health system/Hospital/Academic Center 24%
Private equity-backed 14%
Other 5%

Dermatologists with an ownership stake 55%
Sole owner 28%
Partner 18%
Shareholder 9%
Patients are paying more for healthcare. Dermatologists have more uncollected payments. We can help both of you.

When you accept the CareCredit healthcare credit card, it's easier for patients to accept the care you recommend. And today, that's more important than ever with patients being responsible for a larger share of out-of-pocket healthcare costs. 64% of providers say their biggest concern with billing is the length of time it takes to collect.*

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