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Learning to say no.

For some of us, this is one of the hardest things we do. However, it is a skill needed by those of us who chronically long for 26-hour days. I’ve read many different articles and books about time management but found AAD member Dr. Jennifer Gardner’s advice to be very much on point in today’s hectic and electronically interconnected world. Her thoughts on multi-tasking particularly hit home for me, as I suspect they will for many of you.

This month, we go beyond our previous discussions about bias to address the concept of cultural competency. Racial and ethnic demographics are changing in many parts of the country, and it is likely that some of your patients may not look like you, share your native language, or have been raised in the same country as you. It is important, however, that we be aware of the potential impact that cultural differences may have on our interaction with our patients. In her feature article “Speaking the same language,” assistant editor Emily Margosian explores ways we can assess and improve our cultural competency to ensure that we communicate effectively and respectfully with all our patients. Other highlights of this month’s edition include a review of the recently published dermatopathology appropriate use criteria, which may help you the next time you wonder if you should request those special stains! We also offer helpful information about long-term care insurance (yes, you need it) and strategies for ensuring you maintain your Medicare enrollment.

Melanoma Monday is just around the corner on May 6, 2019! If you haven’t already planned your annual free skin cancer screening, or if you need some help just getting started, see this month’s Asked and Answered. The AAD supports our members with educational materials, skin cancer screening forms, and promotional assistance. To date, we have performed more than 2.7 million free screenings during which we detected close to 300,000 suspicious lesions. Be a part of this wonderful public screening effort! The AAD makes it easy for you and, who knows, the next melanoma may be the one that you find.

March is a time of transition at the AAD, as we bid farewell to our outgoing leaders and welcome the new. We thank Dr. Suzanne Olbricht for her years of dedicated service to the AAD, not only for the innumerable hours she has given us this past year as President, but also for the decade(s) of prior service as Assistant Secretary-Treasurer, Secretary-Treasurer, head of the Scientific Assembly Committee and many other important committee roles. She, Vice-President Ted Rosen, MD, and the outgoing directors leave us with a strong strategic plan to help us keep moving forward in the upcoming years. Incoming President George Hruza, MD, MBA, has some pretty big shoes to fill, but I know he is up to the task, and we wish him well with the transition. And I cannot leave without a shout-out to Barbara Mathes, MD, who will be stepping down as AAD Secretary-Treasurer. Most of us cannot appreciate the many hours spent in this six-year role, and I suspect most mere mortals would take time off at this point to relax. However, I have it on good authority that Dr. Mathes will not be slowing down anytime soon…we wish her well in her next leadership role!

And speaking of transitions, March 15 is Match Day, a day we all remember, hopefully with great fondness! Take a moment to share the memories of Match Day with your colleagues as we mark the start of the next class of future dermatologists!

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR
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TOGETHER, WE ARE MODERNIZING MEDICINE.
FROM THE EDITOR
Physician Editor Kathryn Schwarzenberger, MD, previews this month’s issue.

WATER COOLER
This column features the thoughts of readers like you! This month we asked, “What are your memories of Match Day?”

NEW! ASKED AND ANSWERED
You asked, we answered: What resources does the AAD offer for skin cancer screenings?

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

CRACKING THE CODE
Alex Miller, MD, discusses modifiers 58 and 78.

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

ACTA ERUDITORUM
Can big data estimate prevalence of defective DNA repair variants?

LEGALLY SPEAKING
Obtaining and maintaining Medicare enrollment — what do you need to do?

ANSWERS IN PRACTICE
Jennifer Gardner, MD, discusses best practices for time management.

MONEY MATTERS
Long-term care insurance 101: What dermatologists need to know.

FROM THE PRESIDENT
Academy President Suzanne Olbricht, MD, bids farewell and offers thoughts on the future.

NEW! IN YOUR CORNER
Find out what the Academy is doing to advocate for appropriate coverage/reimbursement for dermatologic care.

ACADEMY UPDATE
Remember colleagues who have recently passed.

CLASSIFIEDS
Who pays the bills? Read more about reimbursement trends.

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What are your memories of Match Day?

“I remember staring blankly at the envelope saying I matched categorical at Indiana. I only had one program listed, and I thought I was going to have to scramble for an intern year! I still have the video!”

— Nikolajs Perdue, MD, Indianapolis

“I remember thinking: I did it! All the hard work was worth it. I couldn’t hide my gratitude. Then, I went around hugging all my medical school classmates because I couldn’t wipe the smile off my face!”

— Omar Qutub, MD, Portland, Ore.

“Knowing I didn’t have to go through that again.”

— Ramin Fathi, MD, Scottsdale, Ariz.

“Crying my eyes out because I was so happy. My Stanford med school deans, mentors, and friends were all so worried that something was wrong, as I was just bawling my eyes out. It was the happiest day ever!”

— Allison Truong, MD, Los Angeles
I want to host a skin cancer screening event. Where do I start, and what kind of resources does the Academy offer?

How wonderful! Hosting a SPOTme® Skin Cancer Screening Program is a great way to show your commitment and passion to your local community and the specialty. Since 1985, dermatologists have made significant contributions to public health by conducting more than 2.7 million free skin cancer screenings, detecting more than 271,000 suspicious lesions and more than 30,000 suspected melanomas.

To get started, the AAD provides members with:

- Screening forms
- Skin cancer handouts
- Posters
- Promotion of your event on the AAD’s website and toll-free hotline

You can access your free screening resources at [www.aad.org/scs](http://www.aad.org/scs).

For more information on program guidelines, practical how-to’s on running a screening, common FAQs, photo waivers, volunteer attestation forms, and more, visit [www.aad.org/SkinCancerScreening](http://www.aad.org/SkinCancerScreening). Happy screening! *dw*

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Looking for more answers?

Send your burning questions to *Dermatology World*’s Asked & Answered column at [dweditor@aad.org](mailto:dweditor@aad.org), and keep an eye out for the answer in an upcoming issue of *Dermatology World*!
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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.

Isn't it interesting how some common warts that we treat seem to go away almost instantly but others persist despite multiple rounds of various treatments? What do we make of this? In the November edition of Dialogues and Dermatology featuring “Molluscum and Warts,” Dr. Tor Shwayder of Henry Ford Health System notes that cure rates might be dependent on the wart’s HPV type. Recent literature out of the Netherlands and Canada demonstrate that some HPVs, like HPV-1, seem to resolve regardless of any treatment, whereas others, like HPV-2, 27, and 57, don’t seem to respond well at all. For example, if a patient has a wart caused by HPV-1, you could put “common household detergent on it, it would get better, and everyone thinks it’s a miracle. But in reality, it was just luck that you had HPV-1.” More research on the relationship between HPV type and wart clearance rate is needed, and it is definitely a hot target for future research.

The “line sign.” When we learn basic dermatopathology as residents, we are often taught to recognize morphea/localized scleroderma by a squared-off biopsy specimen. In his recent manuscript, Max Fung, MD, and his colleagues at UC Davis, analyzed the sensitivity and specificity of the “line sign” (Am J Dermatopathol. 2018; 40:873-878). The line sign was defined as a prominent and straight or linear interface produced by sclerotic reticular dermal collagen or subcutaneous septal collagen with the adjacent subcutaneous fat. They compared cases of morphea, sclerotic graft versus host disease, and necrobiosis lipoidica. They evaluated the cases for “line sign,” “cookie cutter sign,” “square biopsy sign,” high eccrine glands, and presence of mucin. The line sign and high eccrine glands were shown to be the most sensitive histopathologic features for diagnosing morphea. The specificity, however, was not high, likely because it represents a manifestation of collagen thickening. The line sign should be added to our ever-expanding list of clues for assisting in histopathologic diagnoses.

Looking for Dialogues in Dermatology quizzes?

Check out DW’s Asked and Answered column for a step-by-step guide on how to access this Academy resource at www.aad.org/dw/monthly/2019/january/asked-andanswered.
A retrospective chart review of blood test results of almost 5,000 adults and children taking terbinafine or griseofulvin showed that rates of elevated aspartate aminotransferase levels, anemia, lymphopenia, and neutropenia were comparable to baseline levels (JAMA Dermatol. 2018;154(12):1409-16). When lab abnormalities did occur, they were low grade and did not require additional tests or discontinuation of the medication. Because severe drug-induced liver injury is rare and unpredictable, laboratory tests do not determine whether a patient will develop an idiosyncratic reaction. The authors suggest that monitoring laboratory test results during treatment with terbinafine or griseofulvin should no longer be performed in adults and children who do not have underlying hepatic or hematologic conditions. Instead, physicians should screen for underlying hepatic and hematologic disease, counsel patients on recognizing symptoms of hepatic toxicity (pruritus, jaundice, abdominal pain, flu-like symptoms), and perform a history and review of systems in patients taking longer courses.

Like other medical fields, dermatology is no stranger to marketing, including marketing done by dermatologists. Some dermatology practices advertise, as do some of our professional societies. Some dermatologist “thought leaders” lecture on behalf of pharmaceutical companies, and others form their own companies that market dermatology-related products and services to their colleagues or the public.

Social media affords a newer, important channel for dermatology-related marketing. “Influencers” is the term for people, including dermatologists (www.harpersbazaar.com/beauty/health/g10289567/best-plastic-surgeons-on-instagram/), who can influence potential consumers via social media. In all of the above examples, it’s dermatologists who are doing the marketing — or influencing, in social-media speak. But that’s not always the case. A provocative recent article in Slate (https://slate.com/technology/2018/11/medical-students-instagram-influencers-ethics-debate.html) — written by Vishal Khetpal, a medical student who’s also a freelance writer — describes the rise of medical-student influencers in social media.

Some of those medical-student influencers tout non-medically related goods and services. Others, according to Khetpal, hawk medically related — and sometimes dermatology-related — products. Some of the advice is sound, but some of it is not.

The ethics of influencing, Khetpal writes, are complicated, with the American Medical Association and other organizations lacking specific guidance for medical students moonlighting as influencers. (And what about residents, for that matter?)

The ethics of influencing, Khetpal writes, are complicated, with the American Medical Association and other organizations lacking specific guidance for medical students moonlighting as influencers. (And what about residents, for that matter?)

Dermatology’s scope includes cosmetic concerns, making our field particularly fertile ground for influencers of all levels of training. To help retain the trust of the public, it’s time our specialty, and others in the house of medicine, start outlining guidelines for prospective social media influencers at all levels of training.
Most dermatologists are aware that solid organ transplant recipients (SOTRs) are at high risk for the development of cutaneous malignancy, specifically cutaneous squamous cell carcinoma. While there are several reasons why this is the case, the underlying etiology is that immune suppression drives oncogenesis and suppresses the immune system’s ability to detect and eliminate malignant cells. However, translating this basic understanding of risk into enhanced clinical outcomes for SOTRs can be difficult as there are no guidelines on workup and, therefore, it is difficult to know if we are under- or over-treating these patients. Many SOTRs will never develop a SCC, and many who do will go on to have a clinical course resembling that of the general population. So, what features of a SCC in an organ transplant recipient indicate that they are at high risk for poor outcomes?

Lanz, et al, in the January edition of *JAMA Dermatology* retrospectively evaluated 51 SOTRs who experienced nodal or distant metastases, or death due to a SCC and correlated their outcomes to features of the SCC upon initial diagnosis. They found that SCCs that caused these outcomes had a median diameter of 18 mm, a median depth of 6.2 mm, and 41% and 39% demonstrated poor histologic differentiation and perineural invasion, respectively. The five-year survival of this cohort of SOTRs was only 23%. This article provides a general sense of when to consider further evaluation of SCCs in SOTRs can be difficult as there are no guidelines on workup and, therefore, it is difficult to know if we are under- or over-treating these patients. Many SOTRs will never develop a SCC, and many who do will go on to have a clinical course resembling that of the general population. So, what features of a SCC in an organ transplant recipient indicate that they are at high risk for poor outcomes?

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**AADA members are representing dermatologists’ interests with compounding-related policymakers.**

Allison Vidimos, MD, RPh, FAAD, and Seemal Desai, MD, FAAD, serve as physician representatives on the U.S. Pharmacopeial Convention (USP) Compounding Expert Committee and U.S. Food and Drug Administration (FDA) Pharmacy Compounding Advisory Committee (PCAC).

Dr. Vidimos is a pharmacist and a dermatologist and, in 2018, was selected to serve as one of three expert physician consultants to the USP Compounding Expert Committee. She has attended meetings and conference calls, providing valuable physician input during the ongoing revision of the 797 chapter on compounded sterile preparations. In her position, she cites and explains the literature on the safety of how dermatologists currently practice in the office setting, and demonstrates the safety, practicality, cost effectiveness, and efficiency of in-office compounding — especially regarding buffering lidocaine for patient comfort.

Dr. Desai is serving his second term on the FDA PCAC as a voting member. As the only dermatologist currently serving on the committee, he established collegial and collaborative relationships with high-level officials at the FDA, bolstering the AADA’s advocacy on compounding, especially with respect to the regulation of in-office preparations. He helped advocate for ingredient access and policies that are meaningful to our board-certified dermatologist family and our patients.

In addition to these current roles, Drs. Desai and Vidimos participated in a critical meeting in November 2018 with USP, FDA, and CDC leadership, making great strides in helping these organizations understand how our practices operate with quality and safety, and reiterating the need for extending the currently proposed one-hour exemption from the chapter’s requirements, which would affect how far ahead buffered lidocaine can be used, for example. The final revised version of chapter 797 will be forthcoming this year.

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**Can you compound or prescribe it?**

Learn how to ensure the type of compounding you are performing follows FDA regulations at www.aad.org/practicecenter/compounding.
Modifiers 58 and 78

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.

You perform a therapeutic wide excision on a squamous cell carcinoma that was previously incompletely removed. Do you need to append a modifier to distinguish this service from the original surgery?

There are two types of modifiers that may be applicable to procedures done during the postoperative (global) period.

The more commonly used is modifier 58: “Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period” (CPT® 2019). This modifier is typically used in dermatology when a more extensive surgery is done during the first procedure’s 10- or 90-day global period. Characteristically, this occurs when an initial surgery incompletely removes a lesion, or when — based upon histopathology — an appropriate therapeutic wide excision (as for melanoma) is recommended.

The Medicare Claims Processing Manual, Chapter 12, 40.1, specifies use of modifier 58 when:

- A staged procedure is planned in advance or is determined during the initial procedure
- A subsequent procedure is more extensive than the original
- A definitive procedure is done following a diagnostic surgical procedure

The 58 modified procedure triggers the start of an appropriate new 10- or 90-day global period for the staged procedure.

Modifier 58 is not required when an unrelated surgery is done during a postoperative period (see modifier 79), when a related surgery/procedure is done outside the global period, or when a procedure is done consequent to complications from an initial procedure.

When complications from a surgical procedure require a return to an operating room or procedure room for treatment, the service may or may not be billable, and may require appending modifier 78: “Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period” (CPT® 2019). Modifier 78 is appended to an appropriate CPT code describing the additional procedure.

What is included in a post-operative global period and is not separately reportable?

- Treatment of complications in a patient room, minor treatment room, recovery room, intensive care unit (e.g., hemorrhage evaluated and treated in a treatment room, evaluation of ecchymoses)
- Postoperative pain management
- Surgical supplies
- Dressing changes, local wound care, removal of sutures or staples

What may qualify for reporting/billing with a 78 modifier?

- Treatment of complications requiring a return to an operating room (OR)
- Additional procedure related to the first (not meeting the definition for 58 modifier use)
- According to Medicare “an operating/procedure room is defined as any place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, laser suite, or endoscopy suite. It does not include a patient’s room, minor treatment room, recovery room, or intensive care unit.”

Additional details about billing during the surgery global period and the CMS definition of an OR may be found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf.

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.
Examples of complications that may require a return to the OR:

- Hematoma requiring surgical opening of a flap, identification and electrodesiccation of a bleeding vessel, and re-suturing of a flap
- Wound dehiscence requiring re-suturing
- Closure revision due to focal necrosis

A return to the OR for additional treatment is reportable/billable, when appropriate, even when it occurs on the same day as the initial procedure (prior to midnight).

Example 1

You do an incisional biopsy of a suspected melanoma. The histopathology confirms a thin melanoma. You then do a therapeutic wide excision eight days after the initial biopsy. You append a 58 modifier to the excision code, as the procedure was done within 10 days of the biopsy.

Answer: Incorrect. The new CPT biopsy codes, tangential (11102), punch (11104), and incisional (11106), have zero-day global period, meaning that any medically necessary procedure or evaluation performed on any day following a biopsy does not require a modifier. In the above scenario, a 58 modifier was not necessary.

Example 2

Although you do not have an accredited surgical operating room — you do only procedures, including laser treatments, in your office’s designated procedure room(s), which are staffed for that purpose. Treatment of surgical/laser complications, when done in these rooms, may be reportable to Medicare with an appropriate CPT code and modifier 78.

Answer: Correct. Such procedure rooms meet the Medicare definition of OR/procedure room. (Check with your state laws for their requirements).

Example 3

While in your dedicated procedure room for surgical evacuation of a postoperative hematoma under a flap repair done one day before, the patient asks you to evaluate an unrelated skin condition. You diagnose atopic eczema and prescribe a topical steroid ointment along with moisturizer use. You report your services as CPT 10140-78 for the evacuation of the hematoma and 99212-24/25 for the separate evaluation and management (E/M).

Answer: Partially correct. The E/M unrelated to the 90-day global adjacent tissue rearrangement procedure is appropriately reported with a 24 modifier. However, by performing an unrelated E/M service in the same room as the designated operating (procedure) room, you may disqualify the billing of the surgical evacuation of the hematoma. Check with your payers for further clarification and their policy.
Example 4
You excise a lentigo maligna on the cheek with a 1 cm margin, which clinically appeared adequate, and do a complex linear repair. The pathology report reveals an involved posterior margin. Ten days after the initial excision you do a wider excision and report the service by appending a 58 modifier.

Answer: Correct. Although the subsequent procedure was not planned, it was related to the original surgery, was required due to the presence of a positive margin, and was more extensive than the original procedure in that it enlarged the original excision diameter. This meets the definition for appropriate use of modifier 58.

Example 5
Two weeks after an excision and intermediate repair of a nasal basal cell carcinoma that was found to extend to the margins of excision, you excise the involved site with one stage of Mohs surgery. Since the Mohs procedure was related to the initial excision, you report the Mohs surgery as 17311-58.

Answer: Incorrect. No modifier is needed. The 58 modifier applies when a related procedure is done during the global period of the initial procedure. The Mohs surgery was done beyond the 10-day global period for excisions and repairs.

Cracking the Code corrections

The 2019 NCCI first quarter edits brought a multitude of changes when appending modifier 59. The NCCI PTP code pairings do not retain their previous somewhat conceptually challenging pairing characteristics. In many cases the new biopsy codes cannot be substituted for the old 11100 biopsy code in the Column 1/Column 2 pairs.

The premalignant destruction (17000, 17004), malignant destruction (17260-17286), benign (11400-1446), and malignant (11660-11646) excision codes are no longer consistently primary to the biopsy codes. This means that whenever any biopsy technique is done along with these procedures, you should consult the NCCI PTP edits to determine which code receives the modifier. Remember that add-on codes, including add-on biopsy codes, do not require a 59 modifier. Only the code which appears in Column 2 of the NCCI PTP edits, qualifies for a 59 modifier.

Please visit www.aad.org/dw/monthly/2019/january/biopsy-coding-in-2019-part-3 for corrected examples of code pairings, as well as 2019 updates to the Medically Unlikely Edits (MUEs).

Additionally, several examples require clarification. The examples have been clarified online and are as follows, with updates in red:
Example 2  You do an incisional biopsy of a suspected scalp lentigo maligna and destroy 10 actinic keratoses with liquid nitrogen spray. You submit CPT 11106 for the biopsy and 17000 and 17003 x9 for the actinic keratoses destruction.


Example 3  You have learned from the above example and are determined to do this right. You destroy eight actinic keratoses with liquid nitrogen and biopsy two separate clinically atypical nevi using the tangential technique. You submit CPT 11102 and 11103-59, for the biopsies and 17000-59, 17003 x7 for the freezing destruction and 11102-59 and 11103-59 for the biopsies.

Answer: Incorrect. Yow! Why is that? The NCCI stipulates that add-on codes do not merit a 59 modifier. That is why you will not find biopsy and other add-on codes paired in Column 2 of the NCCI PTP (Column 1/Column 2) listing. Avoid appending the 59 modifier to add-on codes, including the biopsy add-on codes 11103, 11105, and 11107.

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

Example 5  You perform three biopsies on three separate clinically deeply palpable tumors using the incisional technique and two biopsies of carcinomas atypical nevi on the right arm and back using the tangential technique. You submit CPT codes 11106, 11107 x2 for the incisional biopsies, and 11102-59, 11103 x2 for the tangential biopsies.

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

However, if some of the lesions are located in the same anatomical ICD-10-CM code grouping, then the payer may adjudicate some of the biopsies as “duplicate.” Stipulate the distinct locations in the “notes” section and be prepared to appeal if inappropriate payment denial were to happen.
For the past few years, many states have been working diligently to allow children to have access to sunscreen and sun-protective clothing in school, where previously it would be restricted to the school nurse’s office because of sunscreen’s status as an over-the-counter drug. The past couple of years, a new issue has emerged for states to grapple with in the realm of sunscreen: oxybenzone, octinoxate, and their effect on the environment when washed off the skin and distributed into the ocean, specifically regarding coral reefs.

Ingredients
Hawaii was the first state to propose legislation to address oxybenzone and octinoxate. In 2017, they introduced more than 10 bills to restrict the use of sunscreens containing these ingredients. Ultimately, in 2018, they passed legislation (effective in 2021) to ban the sale and distribution of sunscreens containing oxybenzone and/or octinoxate citing concerns that they harm coral reefs. On the heels of Hawaii’s new law, the city of Key West, Florida and the state of California have introduced similar legislation. More states, specifically coastal states or states with significant rivers or lakes, may follow suit. Concurrent to the state legislative activity, the Center for Biological Diversity submitted a citizen petition to the Food and Drug Administration (FDA) asking the agency to ban the sale of oxybenzone and octinoxate.

The AADA’s committees, including the State Policy Committee, Regulatory Policy Committee, and the Council on Government Affairs and Health Policy, have held numerous discussions, solicited external reviews of research, and deliberated heavily on the AADA’s stance on this issue. Ultimately, the AADA will focus its efforts on spreading the message of sun safety and the risks of skin cancer due to unprotected or inadequate UV exposure.

The AADA submitted comments to this effect to the Key West City Commission, where the bill was heard and passed unanimously by the commission. The AADA submitted similar comments to the FDA regarding the Center for Biological Diversity petition. Hawaii has introduced new legislation for 2019 that requires the Hawaii Tourism Authority to “promote Hawaii as a destination that protects the environment, coral reefs, and marine life conservation districts and providing guidance on the dangers of sunscreen pollution to coral reefs, especially products that contain oxybenzone and octinoxate."
and how tourists can help protect Hawaii’s pristine environment, marine life conservation districts, and coral reefs.”

**Sunscreen access in schools**

**Illinois** became the first state of 2019 to enact legislation that allows children to bring sunscreen to school without a doctor’s note and recommends school districts incorporate in curriculums a unit of instruction on skin cancer prevention beginning in the 2019-2020 school year. Similar legislation has been introduced in **Arkansas, Mississippi, Missouri, New Jersey, and Rhode Island**, though more is expected. **dw**
AADA calls on FDA to identify root causes of drug shortages and find enduring solutions

FEDERAL NEWS ROUNDUP

BY VICTORIA HOUGHTON, MANAGING EDITOR

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

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

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

Drug shortages

The AADA advocates against barriers that impact patients’ access to care and treatments, particularly drug shortages. Recently, the AADA submitted a letter requesting the FDA Drug Shortages Task Force to:

✓ Create incentives that will encourage manufacturers to produce lidocaine with epinephrine and other local anesthetics during a shortage;
✓ Allow temporary importation of lidocaine with epinephrine due to the severe backlog of orders;
✓ Issue a formal response to address the shortage of critical drugs to inform stakeholders of the current status and forthcoming developments;
✓ Develop a main point of contact for national shortages of specific drugs for physicians seeking drugs on shortage;
✓ Provide regular updates to physicians and the public regarding the status of a national shortage;
✓ Require manufacturers to have plans in place to address and mitigate production issues or delays; and,
✓ Monitor the prices of generic drugs during and after a shortage by both manufacturers and suppliers and work quickly to help mitigate price increases by creating innovative incentives for manufacturers to contain prices.
Compounding

The AADA has been a staunch advocate against restrictions on compounded treatments. Currently, the U.S. Pharmacopeial Convention (USP) Compounding Expert Committee is considering comments as well as other considerations in its revisions of Chapter 797 on compounded sterile preparations.

- The AADA continues to be in contact with USP staff about the Chapter 797 revisions that suggest requirements for: compounding personnel, training, facilities, environmental monitoring, and storage and testing of finished preparations.

- In particular, the AADA has been emphasizing the need for dermatology to have an exemption from a proposal that would require the administration of buffered lidocaine within one hour of preparation.

Medicare Part B drug pricing

CMS recently issued a Medicare Part B proposal that would require half of the country to participate in a new drug pricing model based on an International Pricing Index (IPI), commonly referred to as reference pricing.

Under this proposal, wholesalers would have the ability to negotiate with drug companies to acquire the drugs and the wholesaler would manage distribution to physicians. Physicians would not pay the wholesaler for the drugs and would be immune to fluctuation in pricing agreements for drugs administered under Part B. Additionally, the 6% reimbursement for ordering and storage paid to physicians would be replaced with a flat rate, which is still to be determined.

- The AADA submitted a comment letter to CMS expressing concern with the proposal to alter the formula used to reimburse physicians for the costs associated with drug ordering, storage, and handling that are incurred by practices. dw
Can big data estimate prevalence of defective DNA repair variants?

By Kathryn Schwarzenberger, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Kenneth Kraemer, MD, and Jennifer Pugh, BS, about their recent JAMA Dermatology article, “Use of big data to estimate prevalence of defective DNA repair variants in the U.S. population.”

Dr. Schwarzenberger: Can you briefly describe your study?

Dr. Kraemer and Pugh: With the increasing use of exome sequencing, we decided to see how closely “big data” corresponded with our clinical observations of xeroderma pigmentosum (XP). XP is a rare, recessively inherited, cancer-prone disease that we have been studying at the National Cancer Institute for more than four decades. Patients with XP have defective DNA repair and more than a 10,000-fold increased risk of sunlight-induced skin cancer. Based on the literature and our clinical observations, we estimate that there are about 300 XP patients in the U.S., corresponding to a frequency of about one per million population. However, the results of our study suggest very different frequencies. We looked at three large databases that included more than 200,000 alleles. We identified a total of 156 XP associated mutations — 65 of those mutations were listed in gnomAD which provides information such as genetic variations, allele count, allele frequency, and number of homozygotes.

Dr. Schwarzenberger: Were you surprised by your findings?

Dr. Kraemer and Pugh: We were very surprised. We knew that these 156 mutations were associated with XP by the patients in our cohort at the NIH and the listings in the Human Genome Mutation database. However, the numbers were so surprising that we took a closer look at these variants. We found that two variants alone had frequencies estimating that there should be more than 8,000 people with XP in the U.S. with these mutations. Yet only four individuals have been clinically identified.

Dr. Schwarzenberger: Your findings would suggest that we cannot necessarily equate genotype with phenotype in XP.

Dr. Kraemer and Pugh: Yes, there is a large discordance in the expected number of XP patients based on the frequency of mutations and the actual frequency of clinically diagnosed patients. Based on our results, it appears that disease-associated genotypes might not always yield an expected phenotype. The high frequency of XP mutations, compared to the low prevalence of clinical XP, might suggest that there are other manifestations of these mutations outside of the known XP phenotype. Mutations in known DNA repair genes may contribute to the high frequency of skin cancers in the general population and/or unexplained late onset neurodegeneration. Alternatively, our understanding of the severity of the features associated with these mutations may not be correct.
Dr. Schwarzenberger: Do you think your findings are likely to be true for other rare diseases? What are the next steps?

Dr. Kraemer and Pugh: Others might discover the same discordance when studying rare diseases. There are a few other studies that have reported similar observations with dominantly inherited disorders, including Li-Fraumeni syndrome and DICER1 cancer predisposition syndrome. Previous studies have started by identifying patients with known clinical features and then performing DNA sequencing to determine which genes are defective. We used the reverse approach and began with the data from DNA sequencing and tried to determine the frequency of the predicted phenotype. The results emphasize the importance of following up with patients who might possibly have genomic abnormalities to determine whether they will develop any clinical manifestations. With our study, we are limited in the ability to follow-up on our observations because the DNA was obtained from donors who were promised anonymity. However, a new NIH precision medicine initiative study (All of Us at https://allofus.nih.gov) has a goal of obtaining clinical information as well as DNA sequences from one million volunteers of diverse genetic backgrounds. This will help us better understand the complex relationship of genotype-phenotype correlation as we enter into this developing era of genomics.

Dr. Schwarzenberger: Your study seems to be a cautionary tale about the reliability of big data. As we amass information about dermatologic diseases through DataDerm™ — the Academy’s clinical data registry — do you have thoughts about similar potential pitfalls?

Dr. Kraemer and Pugh: This is a new era. The data available have great potential but there is still much work to be done. This study suggests that gathering clinical information, along with genetic information, can provide a more in-depth understanding of different clinical variations. Until we gain a better understanding of these large data sets, clinicians should approach large genomic databases with caution when trying to correlate genetic variants with prevalence of disease risk. This caution is especially relevant with prenatal testing and identifying disease-associated mutations that may never be expressed.

Funding and support: This research was supported by the Intramural Research Program of the National Institutes of Health, National Cancer Institute, Center for Cancer Research, and Division of Cancer Epidemiology and Genetics. doi:10.1001/jamadermatol.2018.4473.
The Medicare system continues to struggle with the burden of demographics and an increasingly aging population. The Centers for Medicare and Medicaid Services (CMS) attempt to stanch the flow of money out of the system through a variety of methods, including the Medicare credentialing system (referred to as “enrollment”). A physician, non-physician practitioner (NPP), or other non-institutional entity (referred to collectively as “suppliers” by CMS) cannot bill Medicare without billing privileges. Moreover, enrollment requirements extend to suppliers who have already obtained billing privileges. Unfortunately, many suppliers, including dermatologists, do not appreciate what these obligations are and what failure to meet them means.

Reporting obligations, deactivation, and revocation

Most changes in enrollment information must be reported to Medicare within 90 days of their occurrence. Strict standards apply to changes to a supplier’s location, ownership, and certain adverse legal actions, which must be reported within 30 days. The full range of information that must be reported can be seen either on the CMS-855 series of forms (available on CMS’ website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms-CMS-Forms-List.html) or in the Provider Enrollment, Chain, and Ownership System (i.e., “PECOS,” Medicare’s online enrollment system).

The two major consequences of failing to properly maintain billing privileges are: (1) a deactivation of such privileges, or (2) their revocation. A deactivation means that the physician is not able to submit claims for services but may reactivate billing privileges by correcting an error in their enrollment data or submitting a new application. A revocation, however, includes a bar on reapplying for billing privileges for one to 10 years, depending on the reason for revocation. Different events will trigger one of the two penalties. Revocations can be appealed, but deactivations cannot. Avoiding both is critical. Keeping records up to date on an ongoing basis may prove difficult in practice. Several common problems can arise.

Common reporting failures

The range of data that must be reported to maintain enrollment status is broad and can prove complicated. Consider the requirement to report the termination or reassignment of a physician or NPP within 90 days of the termination/reassignment. Often, the departing practitioner will assume their former job will report the change and will not bother to report it themselves. However, a failure to report such change can be imputed to both the departing practitioner and their former practice, and either or both may have their billing privileges deactivated until the issue is resolved. Failure to remove a previous reassignment may also create billing problems, where services might be accidentally recorded as having been performed by the departed practitioner due to errors within a practice’s electronic health records. This may require a voluntary repayment for the practitioner’s improperly billed services to avoid false claims liability.

A practice must notify CMS of a change in ownership, such as when a physician becomes a partner in a group with an ownership interest of more than 5%, which must be reported within 30 days. While the obligation to report such change might seem straightforward, during the tumult...
of making the change in ownership, the practice may neglect to report the change. Similarly, adding or removing a managing employee will trigger the same 30-day reporting requirement. In both cases, the changes will also require reporting the adverse legal history of any new personnel added as owners or managing employees.

Separate from reporting changes to enrollment information as they occur, CMS may require Medicare suppliers to “revalidate” their enrollment data. A revalidation requires the supplier to submit a full enrollment application (as opposed to only submitting the information that is changing), regardless of whether any information has actually changed. This process occurs every five years for suppliers, although CMS may also engage in one or more “off-cycle” revalidations more frequently. A failure to revalidate in a timely fashion may result in deactivation.

Enforcement and appeals
Due to increased enforcement efforts by CMS and its Medicare Administrative Contractors (MACs), the process for resolving problems has become more difficult. For example, we represented a practice several years ago that had its billing privileges deactivated for failing to inform the MAC of the adverse legal history of a physician who had left the practice several years previously, had never been removed from the group’s enrollment account, and who had lost his license to practice. We were able to resolve the matter by communicating directly with the MAC officer assigned to the case and got the group’s billing privileges reinstated retroactively to the date they were deactivated. We were able to prove to the MAC that the obligation to remove the physician from their enrollment account had been added years after the physician had left. The MAC officer agreed to reinstate billing privileges, if the group removed the physician from their account.

In the current environment, this result would be unlikely. The group would instead have to use the appeals system, in which MAC hearing officers, administrative law judges (ALJs), and the Departmental Appeals Board (a panel made up of ALJs) review the facts of cases, considering established law and regulations. However, the ALJs and DAB do not function like federal judges and have no authority to interpret the meaning of regulations in any manner other than as CMS has interpreted them. The appeals process, therefore, often favors the MAC because of the lack of flexibility afforded to ALJs and the DAB. The ideal approach for a dermatology practice is to avoid the need to appeal anything in the first place, by properly maintaining enrollment data.

Conclusion
Maintaining Medicare enrollment credentials is a complicated task that should be entrusted only to someone who understands the enrollment system itself (including how to use PECOS), who understands the requirements regarding timely submission of data, and in a position to monitor and maintain this information on an ongoing basis. It is not simple clerical work. Failure to properly maintain such detailed information can result in a loss of billing privileges and a loss of Medicare revenue, potentially including the need to submit voluntary repayments to Medicare. Coordination with knowledgeable health care legal counsel can assist in these efforts. dw
Dermatology World talks to Jennifer Gardner, MD, assistant professor of medicine and dermatology at the University of Washington School of Medicine, about best practices for effective time management.

Q DERMATOLOGY WORLD: Your bio on the UW website says you “enjoy figuring out new ways to work smarter, not harder.” Where does your passion for work efficiency stem from?

Dr. Gardner: Things typically came pretty easy for me for most of my life, so I didn’t need a real system. I could pretty much keep track of a lot of stuff in my head. Then, I took on more responsibilities — I was starting a family and building a career. It just became too much. I think there was that point of maximal pain where change happens. I thought, ‘well, maybe I’m getting old or I’m just not as good as I used to be’ — whatever it was, I had this feeling that I couldn’t get it all done the way I used to. I thought maybe it’s me, but maybe it’s also my system. When I started looking at it, I realized that I had just fallen into this modern-day trap of trying to do it all — multitasking — which I’m not good at, and I think most people aren’t good at either. I decided to work from that place and truly make some changes. It was hard. Change is always hard. However, once I did, it made a big difference.

Q You often talk to physicians in all stages of their career about best practices for time management. What are the basic tenets of your time management advice?

Dr. Gardner: Generally, as humans we tend to underestimate how much time it’s going to take to do a given task. Just knowing yourself is at the core of all of this. Be honest with yourself and give yourself that time and space to really focus. Otherwise, you’re just doing yourself a disservice. That’s one of the biggest mistakes people make. Also, many people don’t understand the difference between a project and a task. For example, if you have an hour, you may think you might be able to write a paper. Then you’re really upset that you didn’t get it done in an hour. Really, you just didn’t realize that the paper is a project and what you really needed to do was break that project down into a bunch of tasks and then just tackle those in little blocks of time.

Q What advice do you have for getting through some of the big, often overwhelming, tasks that physicians often face?

Dr. Gardner: Essentially, what that does for you is that it defines your ‘yeses’ and then very quickly you can realize your ‘nos.’ People have a very hard time saying no to things, but it’s really important to learn how to say no very politely and also say it quickly. If you know the answer is a no, let that person know right away so then they can move on. If you say yes, and you’re overwhelmed and can’t get it done, that’s where you’ll start to feel bad about not honoring your commitments, which is a bad place to be.
**Q** What do you do personally to ensure that you’re managing your time appropriately?

**Dr. Gardner:** I work in an academic setting, so for me the most important thing is recognizing that I’m either in clinic or not in clinic. When I’m in clinic, I block out the time and I commit to not getting anything else done during that time, except taking care of the patients who walk through my door. I think people think they’re just going to slide in this other work between patients in this block of time that’s already devoted to patients. What they really need to be doing is putting on their calendar other blocks of time for that other work, like email, for example. You may want to block out a couple times a day or maybe you have a couple email days where you’re going to get caught up.

I think it’s human, but 98% of us are single-taskers. We are not multitaskers. I think identifying that has been important to me. ‘I’m in clinic right now and I’m going to be mindfully present for this work. Then I will be doing email in a different time slot, and I’m not going to do anything else.’ You’re going to be most efficient and most productive at that one task. Studies have shown that if you’re multitasking, you’re really just serially single-tasking and task-switching, which makes your brain really tired. If you’re doing that throughout the day, by the end of the day you’re going to have nothing left and you’ll be on empty. If you’re really present and mindful and do the task at hand and do it as best you can, and then be done with it, I think that can be really uplifting and energizing in some ways, even though it’s the same amount of time that you’re doing that work.

**Q** Physicians have so much on their plates today, in addition to patient care — particularly administrative tasks. What should physicians do to ease that burden?

**Dr. Gardner:** You have to say, ‘Okay, maybe it’s not important to me, but it has to get done.’ There are lots of those things in our jobs and our lives. Ultimately, you must ask yourself, ‘Am I the person who needs to be doing this?’ and ‘Am I the person who does this best — even if I like to do it and don’t mind doing it?’ If the answer is no to those questions, I think it’s worth spending some time looking into delegating or outsourcing that type of work, so that it gets done but you’re not going to be run-

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If you have patients with these conditions, please reach out to the contact below to discuss further. PustularDermStudies@threewire.com
ning into a time issue. You can then spend your
time doing the things that you have to do, or that
you do really well — patient care.

**Q** How can technology help with time
management? Can it hurt?

**Dr. Gardner:** I do think technology is here to
stay, but we have the choice to figure out how to
make it work best for us. That, I think, is the es-
sential part of this. We must decide: How is this
actually going to help me? Do I have to use this?
How do I get this to work best for me? The tech
settings, when it comes out of the box, may not be
the ones that work best for you, but you have the
choice to go in and learn the system and put in
the settings that work best for you and to keep the
distractions out.

That is important: Everyone has a smartphone
these days and they have, arguably, made a lot
of things easier and better. However, more than
not, they’ve distracted us and taken us away from
productivity. That is not a weakness of any one
person. I think that is exactly how they’ve been
designed to work. I also think you need to be care-
ful of shiny object syndrome or FOMO [Fear of
missing out]. You don’t need to invest in every new
piece of tech that comes out, and don’t assume
it’s going to be the one tool that’s going to solve
all of your productivity problems. You just need a
system and a very small handful of tools that work
great for you and the way you work, and just run
with it. If you do that, you don’t need all the other
stuff. It just becomes more stuff.

**Q** Which Academy resources are
helpful to you in terms of managing
your time?

**Dr. Gardner:** I love the prior authorization
appeal letter generator (www.aad.org/practice-
center/managing-a-practice/prior-authorization-
assistance/patient-letter-template). I think it’s
genius. It’s so helpful for us when we see a patient
and we’re having a hard time getting a treatment
approved. With the letter generator, I know I don’t
need to go back and reinvent the wheel. That kind
of resource is wonderful in a busy clinical setting
when you just want to get what you need for your
patients.

I also love the Academy guidelines. I teach to
those with my residents and look to them to make
sure I’m on track. Also, the Academy’s educational
modules are wonderful, and I often direct my
residents to those resources.

**Q** Overall, why should physicians
spend time focusing on time
management?

**Dr. Gardner:** It’s basic stuff that I wish I had
been formally taught in medical school or resi-
dency. Now it’s one of my passions, because I
think it’s very important for people to take a step
back and take time to learn these things. It may
feel like you’re taking time away from the work
to figure out how to be more productive, but it’s
so important going forward. It makes all the differ-
ence in the world. _dw_

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Long-term care planning
Early implementation can reduce family stress while improving wealth protection

BY DAVID B. SNYDER, JD, CLU®

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.

What comes to mind when you consider the phrase “Long-Term Care”? You may think of the services provided by a nursing home, assisted living facility, or in-home caregiver. In fact, long-term care can be any one or a combination of these services needed for yourself, your spouse, your parents, or in-laws. One might think that dermatologists, as physicians, anticipate the medical, family, and financial challenges of long-term care and make proper planning decisions before the need for care creates a tension-filled issue. Unfortunately, as a firm advising more than 1,000 physicians, we do not find this to be the case.

In this short article, we describe the background of long-term care planning and give an overview of some of the key issues all physicians should understand.

The challenge
As physicians, dermatologists should be aware of the medical reasons people need long-term care services. Very simply, as we age, basic daily functions (called Activities of Daily Living or ADLs in long-term care jargon) become difficult to perform without assistance. ADLs include eating, bathing, dressing, toileting, transferring, and continence.

Dermatologists should also be aware that assistance with such activities — whether in a nursing home, in a skilled nursing facility, or even at home — can be very expensive, and the need for assistance may last for years. In fact, the annual cost for full nursing home care can be $100,000 or more. Thus, for both family and financial reasons, giving careful thought to these challenges in advance of a long-term care need is wise.

Looking at the macro statistics [www.morningstar.com/articles/823957/75-mustknow-statistics-about-longterm-care.html], just a few numbers can tell the story:

1. **15 million**: The number of Americans expected to have a high long-term care need by 2050.
2. **52.3%**: The expected percentage of people turning 65 who will have a long-term care need during their lifetimes.
4. **$470 billion**: The dollar value of long-term care provided by unpaid caregivers, 2013.
5. **129,000**: Number of individual long-term care insurance policies sold, 2014.
6. **305,068**: Number of hybrid life/long-term care policies sold to individuals, 2013.

What does the government provide?
Generally, the government will pay for long-term care as part of the Medicaid program, but only after the care recipient meets certain state-specific income, asset, and physical minimums. Said differently, you must be poor by state standards before the government will assist you under the Medicaid program, and the assistance will likely be provided in a nursing home. For most dermatologists and their spouses, meeting these minimums would mean losing most of the assets they have worked hard to earn over their careers. However, for the parents and in-laws of some physicians, Medicaid qualification may be a suitable solution. With advance planning, the use of Medicaid trusts and other tools to qualify for benefits by moving assets to family members can be a viable option that should be explored.

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Having family members provide care
While siblings, children, grandchildren, and farther-removed family members can play an important role in providing care, there are myriad issues to consider, including time management, geography, and funding. Think about how pressed for time most people are today, balancing the demands of their families and careers. Ponder, also, the challenges that could arise if some family members live near the person needing care and others do not. Will all geographically close relatives split duties equally? Will some be compensated for their time? At what rate? Can family members do a good job of providing care — or even an adequate one? Even in the best of circumstances, these are issues that can build resentment, anger, and stress, and can often lead to serious repercussions throughout the family.

Paying out of pocket
Certainly, many dermatologists can afford to pay out of pocket for months, if not years, of services for themselves and their spouses. However, is this a wise choice from an overall financial-planning perspective? It may not be, especially when insurance coverage is considered (see below). Even more problematic may be paying out of pocket for parents or in-laws, especially when other siblings do not have the ability or desire to pay their “fair share.” Anger, stress, and resentment among family members are common in these situations.

Insurance coverage
Purchasing insurance to cover long-term care needs can be a sound part of a financial plan. Long-term care insurance is an insurance product that pays for long-term care services in many settings, such as at home, in a nursing home, assisted living facility, or adult day care facility. Since there are many different long-term care insurance plans and insurance carriers who offer them, it is important to make sure the plan you select will meet your foreseeable needs. Some plans cover facilities-only care, while others cover facilities care and home care. Some policies exist as stand-alone long-term care policies, and others can be hybrid life insurance/long-term care policies.

When deciding on the best choice for you or a family member, it is essential to work with an experienced insurance agent who is familiar with the products in the marketplace. Also, as with most insurance, costs typically increase with the age of the insured, so there can be a significant benefit in locking down favorable coverage sooner rather than later.

Conclusion
Because long-term care planning will impact nearly every family in some way, it is wise to proactively examine options for you and family members before the need for care arises. Timely implementation of long-term care planning strategies can have a positive effect on family dynamics, while helping to protect the wealth a physician has worked hard to earn. dw
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Speaking the same language

How cultural competency can improve communication — and care outcomes
Sometimes a seemingly innocent gesture can have unintended consequences. In 2012, former President Barack Obama sparked a minor diplomatic scuffle after kissing humanitarian Aung San Suu Kyi on the cheek during a visit to Burma, upsetting cultural boundaries on appropriate contact between men and women. More notoriously, pop star Justin Bieber once remarked during a visit to the Anne Frank House that he hoped the Holocaust victim, "Would have been a 'belieber.'” While pop culture is rife with these occasionally amusing (and often embarrassing) cultural gaffes, for physicians, a lack of cultural competency can have implications that go far beyond simply offending a patient.

While the significant health disparities that exist for underrepresented minorities in the United States have been widely reported on, often unaddressed is the poor quality of physician-patient interactions among these groups that can play a key part in their negative health outcomes. Particularly as the racial and ethnic demographics of the country continue to change, dermatologists’ ability to demonstrate cultural awareness during patient visits will become increasingly crucial, according to Amy McMichael, MD, professor and chair in the department of dermatology at Wake Forest Baptist University Health Sciences. “Cultural competency is important even as we are diverted from the tasks of taking care of patients with paperwork. Taking our eye off the ball of recognizing what patients need from us in a culturally sensitive way can lead to poor care and unsatisfied patients who are not compliant with therapies,” she said.

Abel Torres, MD, JD, MBA, professor and chair in the department of dermatology at the University of Florida College of Medicine, agrees that cultural competence should be a key asset in any physician’s toolbox. "The key to effective leadership and effective patient care is communication, and communication requires cultural competency. While you can meet all the other demands that come with being a physician, at the core of it, if you fail at communication you will fail at accomplishing your goals — whether those be good patient care or leadership in dermatology.”

This month, *Dermatology World* talks with leaders across the specialty to discuss:

- Why cultural competency matters to dermatologists
- Common examples of cultural sensitivities in the clinic
- Strategies for improving cultural competency >>
Nuances of the skin: Cultural competency and dermatology

Although demands on physicians are already multifold, “With the increasingly diverse patient population in the United States, there is an ever-growing need for physicians and other health care providers to improve health care delivery beyond having exceptional clinical skills and successfully achieving system-wide quality measures” (J Am Acad Dermatol. 2017;77(6):1159-1169).

Given these expectations, what does cultural competency for dermatologists look like — and how is the specialty doing so far? Dermatology’s lack of diversity has been well documented, and improving workforce representation has become a priority in recent years, particularly as racial and ethnic disparities within the specialty have been shown to have clinical implications among minority patient populations. “Diversity among the medical workforce has been linked to better patient care,” said Dr. McMichael. “Minority physicians are more likely to care for patients of their own racial or ethnic group, and race-concordant visits often have higher patient satisfaction than non-race-concordant visits.”

While research and papers investigating diseases affecting skin of color populations has picked up over the past decade — “Often by researchers who are also skin of color dermatologists,” notes Dr. McMichael — representation within the specialty still falls short when compared to the general U.S. population, especially in light of a projected

Dermatology demographics

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<th>United States dermatology workforce</th>
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<tr>
<td>4.1% African American</td>
<td>14.3% African American</td>
</tr>
<tr>
<td>4.7% Hispanic</td>
<td>17.4% Hispanic</td>
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Until the specialty catches up, dermatologists can help bridge the gap through improved cultural competency and communication when treating patients of a different cultural or ethnic background than their own. “One example that I encounter each week in my practice is many African-American women with seborrheic dermatitis who are told by their primary care physician to use anti-dandruff shampoo daily for weeks or months,” said Dr. McMichael. “This practice can cause significant breakage of hair in African American patients due to innate fragility of the hair shafts, and patients can end up with worse hair issues by seeing someone who is not culturally competent enough to know that most women of African descent wash their hair every 1-2 weeks. In this case, a medicated shampoo can be recommended for weekly use and other treatment options for scalp treatment can be offered.”

“Cultural competency actually helps the system at large, because it’ll expedite the visit. Communication with patients — which is critical to good patient outcomes — will be enhanced. In the end, patients will do better, and there will be fewer return visits for failure of treatment,” he explained. “Right now, in the health care system, we have physicians talking at patients and patients talking at physicians, and the communication link has become poor. As a result, we must have ways to more effectively communicate with patients; that includes being able to reach out when the patient’s background is different than our own.”

In the clinic: Examples of cultural competency

How might cultural competency come into play during a visit with a dermatology patient? One example could involve making additional accommodations during a skin exam for patients whose cultures do not allow them to be undressed in front of a member of the opposite sex. “In San Francisco, we have patients from essentially everywhere in the world, and one of the things I try to be aware of is sensitivity among different cultures about women being examined,” said Dr. Berger. “I’m always careful to have a chaperone there, and make sure we’ve talked about what’s going to happen. I think there’s a general awareness we should have when there’s a gender discrepancy between the physician and patient, but there can be a second cultural level where we want to make sure we’ve done everything necessary to make the patient feel comfortable.”

Communication styles between physicians and their patients can also differ based on cultural norms. “A perfect example is that in Hispanic families there can be an unwillingness to discuss negative issues in terms of poor health or a bad diagnosis. As a result, when questions are asked, the answers that patients give may be very misleading, especially if there’s an elder in the room and the family doesn’t want to say anything to make the elder think they’re sick,” explained Dr. Torres.
“I’ve seen it on a personal level coming from a Spanish culture, so understanding that this is a possibility — and perhaps separating the elder when giving medical information — or recognizing that it’s a possibility that the elder’s not being told their true diagnosis would be very important for the care of the patient.”

Translation services can be one way to overcome communication gaps imposed by language barriers. “A key part of cultural competence is to also ensure you have adequate translation support, so you know the information you’re giving to the patient is getting through,” said Dr. Berger. While translating through a patient’s family member can be a last-ditch option, medical information may not be reliably conveyed. Dr. Berger instead recommends that, in a pinch, dermatologists can look into on-demand translation services. “One resource everyone can access is through AT&T or other phone services where you can get a competent medical translator on the phone to translate during the patient visit.”

Read more about language assistance services for non-English-speaking patients at www.aad.org/dw/monthly/2019/january/language-assistance-services-for-non-english-speaking-patients.

Recognizing the potential social challenges that a patient may be facing due to their skin condition is another aspect of cultural competency, particularly when dermatologists and patients don’t see eye-to-eye on severity or treatment. “If you see someone from the Indian subcontinent who has had a change in pigment — especially a loss in pigment — culturally that’s a major burden for that patient. Understanding what’s important from the patient’s perspective is critical,” said Dr. Berger. “For example, I may have a patient who has a lot of itching and rash and I may think the itching is what’s bothering them the most, but the patient may be more embarrassed by the rash. That would redirect how we might approach that patient.”

What to say, what not to say
While few physicians deny the value of cultural competency in theory, actually putting it into practice can pose a much more daunting task. However, the expectation that dermatologists should be able to anticipate the nuances of every patient’s cultural taboos, practices, and beliefs is ultimately an unrealistic one, according to Dr. Berger, who instead suggests physicians approach patients of different backgrounds with a genuine sense of curiosity and acceptance. “I think it’s just a level of alertness — the ability to listen to the patient and find out what their expectations are without making any generalizations,” he said.

“Sometimes that means asking, because no one can be culturally competent across all cultures — that’s impossible. The only way to know is to ask. In other words, ‘What about what’s going on with your skin is most important to you?’ Oftentimes, the answer can be quite surprising.”

Dr. McMichael agrees. “The best approach is to keep an open mind about cultural practices and ask the patient to help clarify what is likely to fit with their personal care practices, their work schedule, budget, and ability to return to the medical office for follow-up. This is the same that we do for all our patients. It is also a good idea to learn about the patients who are common to your practice at the very least.”

In general, culturally competent care can be characterized by these key aspects:

- A patient-centered approach
- An established rapport
- Shared decision-making

To get there, there are several steps dermatologists can take to assess and improve their overall cultural competency.

1 Consider your underlying biases. Physician bias can play a significant role in patient care and outcomes (Read more at Dermatology World’s November 2018 feature story “(Un)Equal care for all?” at www.aad.org/dw/monthly/2018/november/un-equal-care-for-all). To recognize and ultimately mitigate the effects of bias, dermatologists can identify their own personal biases through a variety of implicit association tests available online, including Project Implicit, offered by Harvard at https://implicit.harvard.edu/implicit/. “I think now we have more awareness of these issues,” said Dr. Torres. “In part because of many different events that have been happening lately in our general culture — for example the #MeToo movement has increased
understanding of sexual harassment — and I think within that context people are also recognizing that sensitivity surrounding culture, race, and sexuality is important because it plays such a large part in avoiding misunderstandings and communicating properly with patients.”

2 **Hone your patient interview skills.** Knowing what to ask (and what not to ask) can be a key component to building trust with a patient of a different background while arriving at the best possible treatment plan that’s amenable to both patient and physician. A good starting point for improving patient interview skills is the RISK (Resources, Individual Identity, Skills, Knowledge) Model developed by Kagawa-Singer et al (Acad Med. 2003;78:577-587), which can help physicians build a template of questions phrased to obtain key information during a patient history without potentially causing offense, which includes sample questions such as, “In what language do you feel most comfortable talking?” and “Do you use any complementary or alternative medicine?”

3 **Build a rapport.** Establishing common points of conversation with a member of a culture or group you know nothing about can be hard. Despite the challenge, a good rapport not only breaks down barriers between physician and patient but can also potentially increase a dermatologist’s insight into cultural views on health and healing (J Am Acad Dermatol. 2017;77(6):1159-1169). Physicians can improve their connection to a particular population by volunteering at diverse clinics or hospitals, attending cultural performances or festivals in their local community, or even potentially learning greetings in different languages that are spoken by a significant portion of their patient population. “It is impossible to learn the nuances of each cultural group, but I recommend dermatologists start with their own community,” suggested Dr. Pandya. “What is the racial and ethnic breakdown of the population you serve? For example, if one practices in a community with many Latino residents, one can read articles and books about the experience of Latinos in the United States, the history of their countries of origin, their traditions, faiths, favorite foods, and family dynamics. One can view movies and attend festivals of Latino music, dance, and theater. This can be quite enjoyable and provide rich conversation starters with Latino patients in the office. It will help the dermatologist understand their Latino patients better, which may then improve rapport, compliance, and treatment results.”

4 **Access online resources.** There are many online resources available to physicians seeking to improve their cultural competency that include online training tools, case studies, small group learning materials for practice staff, information about immigrant and refugee groups, and other various curricula and assessment programs. Key resources include:

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<th>Program</th>
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<tr>
<td>Health Resources and Services Administration, Department of Health and Human Services</td>
<td>Culture, Language and Health Literacy</td>
<td><a href="http://www.hrsa.gov/cultural-competence/index.html">www.hrsa.gov/cultural-competence/index.html</a></td>
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<tr>
<td>CDC</td>
<td>Practical Strategies for Culturally Competent Evaluation</td>
<td><a href="http://www.cdc.gov/dhsp/docs/cultural_competence_guide.pdf">www.cdc.gov/dhsp/docs/cultural_competence_guide.pdf</a></td>
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5 **Attend in-person education.** Structured live education can help assess dermatologists’ knowledge, cultural sensitivity, and respect for underrepresented groups. “I recommend looking to your local dermatology association,” said Dr. Torres. “The American Academy of Dermatology also has different course offerings and online resources that can be helpful in that regard.” Visit www.aad.org/meetings for more information on upcoming education opportunities and workshops.

Dr. McMichael also cites the value of hands-on education. “The Skin of Color Society, the American Academy of Dermatology Diversity Task Force, and the National Medical Association Dermatology Section all provide education on this issue,” she said. dw
With the introduction of the ‘copay accumulator,’ the battle between insurers and drug makers has escalated. Meanwhile, patients pay the price.
Copay accumulators debuted last year going largely unnoticed by physicians and patients, but all that could change this year as more insurers adopt them.

Under insurance plans with this policy, copay coupons given to patients by branded drug manufacturers will no longer count toward patients’ deductibles and out-of-pocket maximums. As a result, patients will pay more money for their medications, and those who are prescribed biologics and have high-deductible plans will likely be the hardest hit.
Copay accumulators
Insurance companies have adopted copay accumulators to direct patients to less expensive medications, according to Joerg Albrecht, MD, chair of the Academy’s Drug Pricing and Transparency Task Force. The pharmacy benefit managers (PBMs) and large insurers that have implemented this policy are CVS Caremark, Express Scripts, and OptumRx, as well as several Blue Cross Blue Shield plans, Molina Healthcare, and UnitedHealthcare.

“It’s just an escalation of the war between insurers and the pharmaceutical industry,” said Daniel D. Bennett, MD, a member of the Academy’s Drug Pricing and Transparency Task Force. Historically, pharmaceutical companies have made their drugs available to patients at little cost through copay assistance programs, which typically lasted long enough for the patients to pay for their deductibles. In many cases, these programs made very expensive drugs affordable for patients. While the patients saw little cost, the insurers and employers have seen their costs for these drugs escalate, he explained.

Copay coupons have been blamed for contributing to rising health care costs by encouraging patients to buy specialty drugs even when cheaper brand-name or generic drugs are available. A 2016 *American*

<table>
<thead>
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<th>How will the copay accumulator impact me?</th>
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<td>Consider the following scenario:</td>
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<table>
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<tr>
<th>Month</th>
<th>Patient’s Cost (monthly out-of-pocket costs)</th>
<th>Manufacturer’s Cost</th>
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<tr>
<td>January</td>
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<td>December</td>
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In this scenario, you will receive a $2,000 bill for your prescription drug in May. Why? The $8,000 copay card only applied to four months of treatment (January through April) since the manufacturer’s cost is $2,000 per month. Starting in May, you are responsible for the manufacturer’s cost of the prescription drug until you hit your deductible. Accordingly, in this scenario, you are responsible for $2,000 per month starting in May until reaching your $6,000 deductible in July. Once you hit your deductible, you owe a $500 coinsurance per month for the remainder of the plan year, which is 25% of the manufacturer’s monthly cost.
Economic Journal: Economic Policy study found that coupons increased branded sales by more than 60%, entirely by reducing the sales of generics. The introduction of a copay coupon is estimated to increase total spending by an additional $700 million to $2.7 billion over a five-year period following generic entry for the 23 drugs identified in the study. That breaks down to $30 million to $120 million per drug (2016; 9(2): 91-123).

In response to copay coupons, which have grown steadily since they were introduced in the mid-2000s, insurers and/or PBMs have recently implemented copay accumulator policies that shift much more of the cost to patients who now must fulfill their deductibles when the copay assistance programs run out. Essentially, the copay coupon can no longer be used by the patient to pay for deductibles. The health plan/PBM may receive the full value of the manufacturer copay card plus the deductible paid by the patient, thus significantly increasing the money they receive. It should be noted that Medicare bans the use of coupons as the Centers for Medicare and Medicaid Services considers them kickbacks. Additionally, CMS has proposed banning the use of copay coupons in qualified health plans in the health insurance exchanges.

Growing trend
According to research conducted by Zitter Health Insights — which looked at 49 health plans and PBMs with 147 million covered lives — 44% of commercial lives are covered by payers that implemented a copay accumulator program in 2018. Another 27% of plans expect to adopt this policy by or after 2019.

Employers are getting on board as well. Only 17% of employers used copay accumulators in 2018, reported the National Business Group on Health based on its survey of 170 employers. In 2019, 29% of employers will use them. Among the large employers implementing copay accumulators are Walmart, Home Depot, Allstate, and PepsiCo. Some of these

Educating patients about copay accumulators
Physicians may want to prepare their patients for higher out-of-pocket costs this year in case their insurer has implemented a copay accumulator program.

“It is very difficult for patients to know if their insurance product includes a copay accumulator program, and there is no way that we, as physicians, can know,” Dr. Bennett said. He recommends that patients scrutinize their insurance plan contracts to find out if it has a copay accumulator. Explain that they go by different names. For example, it is called a Coupon Adjustment: Benefit Plan Protection Program at UnitedHealthcare, an Out of Pocket Protection Program at Express Scripts, and a Specialty Copay Card Program at CVS Caremark.

To that point, a coalition of nearly 60 patient advocacy organizations called on all 50 state insurance commissioners and attorneys general last May to investigate copay accumulator programs as a possible violation of consumer protection laws. The coalition members maintain that insurers are not being transparent about adding this policy to their plans, but rather burying it in hard-to-understand language for consumers.

If patients can no longer afford their medications because of the policy, Dr. Bennett will refer them to his institution’s social services program to help find assistance for necessary medications. “For better or for worse, I also make sure patients understand that we as voting citizens are ultimately responsible for the American health care system,” he said, “so if they want a better system, they must pay attention, be engaged with their elected officials, and vote.”

The Academy has developed patient resources about copay accumulator policies that can be downloaded from its website. These documents explain what they are, how they will impact patients, why the policy is being implemented, and what to do if patients are impacted by it. The Academy also offers tips for reducing drug prices for patients that can be downloaded from its website. Access these resources at www.aad.org/drug-pricing.
programs target therapies for psoriasis, among other medications sold through a specialty pharmacy, according to Reuters. As more employers adopt this policy in 2019 and beyond, more patients will face higher out-of-pocket costs for medications, noted Ashley John, a manager in Advocacy and Policy at the AADA.

**Potential impact on patients**

Copay accumulators will impact patients who require expensive specialty medications the most, Dr. Bennett noted. Psoriasis patients will likely be impacted most frequently. Atopic dermatitis patients will likely be affected as well, as new treatment options enter the marketplace. Similarly, as more patients with advanced melanoma stand to benefit from newer targeted therapies, they can expect to face higher costs as well.

“Patients who have a high-deductible insurance product with a copay accumulator program can expect to face very high costs when the drug company’s copay assistance program ends,” Dr. Bennett said. In the case of a patient who is taking a medication that costs $2,000/month, the patient uses a copay coupon valued at $8,000, which will run out in four months. The patient has to pay $2,000 for the next three months to pay for the medication until the patient meets their $6,000 deductible. After that, the patient is required to pay co-insurance, which is usually 25% of the manufacturer’s cost. That translates to $500/month for the rest of the year for a total patient out-of-pocket cost of $8,500.

Before the copay accumulator policy, the deductible would have been met by using $6,000 of the $8,000 coupon. Once the coupon is used up after four months, the patient would only be responsible for the 25% coinsurance ($500/month) for the remaining eight months, for a total patient out-of-pocket cost of $4,000 (see sidebar for a full breakdown).

“I predict that some fraction of these patients will simply choose not to purchase their medications, leading to poorer outcomes,” he said. More patients, who otherwise may have been treated effectively as outpatients, may be hospitalized for severe psoriasis or atopic dermatitis. In addition, more patients may choose less effective, or more dangerous, older medications, Dr. Bennett added.

Many patients, especially those taking biologics, can’t afford these drugs without any assistance, Dr. Albrecht said. Consequently, this policy could have devastating consequences for these patients.

“The Academy’s concern is what happens to patients when the coupons run out,” John said. For some of these medications, there are no lower-price therapeutic alternatives, so this policy will decrease medication access for patients who cannot afford the full cost of their deductible. There is concern about adherence issues particularly for patients with psoriasis who are stable on a therapy and due to financial burden can no longer afford it. Finally, these types of policies could spill over into other health services costs, as patients who can’t afford their medications may utilize higher-cost options such as hospitalization, she said. “We need to control health care costs, but not by leaving the patient with the bill,” John added.

**Curbing costs...for now**

Some data suggest that these policies are controlling costs, just not for patients. Reuters reports that drug manufacturers are monitoring the effects of copay accumulators and considering implementing measures to counter the policies. Among them could be new payment options that would go undetected by PBMs, enabling patients to continue benefitting from the copay coupons, or new discounts for payers. Just as insurers found a way to work around the copay coupons, Dr. Albrecht expects drug manufacturers to come up with a work around, perhaps in the form of a rebate, for the copay accumulators.

“While the insurers and manufacturers fight their war, patients are caught in the middle,” Dr. Bennett concluded. “I don’t see any evidence that either party really has patients’ needs in mind.”
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.*

The CareCredit credit card, with promotional financing options, can be used for deductibles, copays, medical and aesthetic dermatology treatments, prescriptions and more.** And you get paid within two business days. It’s a healthy thing for everybody.

* CareCredit Payment Benchmark Study with Enrolled Providers, conducted by Chadwick Martin and Bailey, December, 2016
** Subject to credit approval.
Putting care into context

New dermatopathology appropriate use criteria from ASDP help guide patient care
A plethora of new diagnostic tests are enhancing the ability of dermatopathologists to guide dermatologists and their patients toward timely, effective treatment. But knowing when to use which advanced test can be challenging, and the cost of some tests can prompt insurers to balk at reimbursement. The American Society of Dermatopathology (ASDP) tackled both issues head on by systemically developing a set of appropriate use criteria (AUC) for a dozen ancillary tests. The final AUC have been published in the *Journal of the American Academy of Dermatology* (available online at doi.org/10.1016/j.jaad.2018.04.033) and the *Journal of Cutaneous Pathology* (2018;45:563-580). In addition, five recommendations based on the AUC have been published on the American Board of Internal Medicine Foundation’s Choosing Wisely® campaign website (see sidebar).
“The cost of health care continues to increase, partly because of wonderful new technologies that are available. They improve patient outcomes, but they also cost money,” said Dirk M. Elston, MD, professor and chairman of the department of dermatology and dermatologic surgery at the Medical University of South Carolina in Charleston. “Going forward, there have to be criteria regarding what [tests are] appropriate when. Someone must develop them, and payers will do it unless the societies do. Who knows more about the actual practice of medicine? The physicians.”

Dr. Elston — a former AAD president who was president of the ASDP in 2015, when an AUC task force was formed — pointed to the Academy’s creation of AUC for Mohs surgery as a “very successful effort. Building on their success, we launched a similar effort for some of the reflex testing that would be done in a dermatopathology lab. We did it on a shoestring budget with volunteer time and the end product is very good.”

**Evidence bolsters expertise**

From the outset, the ASDP adopted the methodology of RAND/UCLA that combines scientific evidence review and analysis with clinical experience and expertise. The process, as described in both manuscripts, began with the establishment of four subgroups: lymphoproliferative, melanocytic, soft tissue, and other — with ‘other’ meaning tests not included in the other categories. Each group then chose two or three ancillary studies to develop AUCs; created a set of definitions to clearly explain the meaning of assigned terms and histologic diagnoses; and developed clinical scenarios to simulate situations most likely to be encountered in clinical practice. The tests were selected “based on their utilization and the preliminary thought that questions about those tests have already arisen,” said Dr. Elston. For example, “there were questions from payers about the testing available for melanoma and lymphomas.” A total of 211 clinical scenarios were chosen to provide context for the appropriateness of each test; the list was “not intended to be exhaustive, but to represent at least 85% of anticipated scenarios,” according to both manuscripts.

A literature search extending from 1940 to 2016 yielded 239 articles, which were summarized and provided to a rating panel of 17 members. Panel raters, who were screened for financial conflicts of interest, included dermatologists and dermatopathologists.

Among the panel raters were two representatives from the AAD (both non-dermatopathologists) and two representatives from the College of American Pathologists. “You don’t want to have an ‘inside baseball’ situation, where everyone is very similar in terms of their training and their views,” said AAD representative Murad Alam, MD, vice chair of the department of dermatology at Northwestern University’s Feinberg School of Medicine. “Since the whole purpose is to guide clinical care by selecting the best diagnostic tests, you want to have some people who are clinicians, not pathologists.”

Armed with literature reviews and clinical scenario booklets, the panel members used a nine-point scale, ranging from “rarely appropriate” to “usually appropriate,” to rate each test in the context of the clinical scenarios assigned to it. They were instructed not to consider the cost of the test. “Tests are rarely always appropriate, or never appropriate. Rather, they’re on a spectrum,” said Dr. Alam. “Even if a test is usually appropriate, that doesn’t mean you have to do it. It just means that it may often be the right course of action, but clinical judgement is essential for evaluating each specific instance to determine if a test, in fact, needs to be done.”

**“Even if a test is usually appropriate, that doesn’t mean you have to do it. It just means that it may often be the right course of action, but clinical judgement is essential for evaluating each specific instance to determine if a test, in fact, needs to be done.”**
A dermatology at Saint Louis University. “One of the biggest examples was the qRT-PCR. When the ratings were done, there wasn’t very much literature on the test.”

Putting AUC into practice
Dermatologists, as well as dermatopathologists, can now refer to the AUC as they consider what tests would or would not likely benefit a particular patient. “Because the dermatologists get the report from the dermatopathologists, [the dermatologists] need to be able to sometimes make decisions about whether further testing is appropriate or not,” said M. Yadira Hurley, MD, professor of dermatology and pathology and director of dermatopathology at Saint Louis University School of Medicine, and chair of the AUC task force. “As an example, a lot of the tests we looked at were tests that many dermatopathologists do not do reflexively, such as FISH. We polled dermatopathologists at an ASDP meeting and learned that many were asking the dermatologist before performing the test, in some cases, because they were aware the test was expensive and may not be covered by the patient’s insurance. In other cases, they needed more clinical information.” Another example of the continued dialogue and importance for dermatologists to be aware of the dermatopathology AUC is in cases where testing for human papillomavirus is being considered. “As dermatopathologists, we get a lot of requests from our dermatology colleagues to do the test,” said Dr. Vidal. But “both parties need to be aware of the literature and recommendations. The literature is most robust on the use of in situ hybridization for testing, and on histologic findings that are diagnostic for condyloma. There are also many psychosocial implications related to testing. Hopefully, the AUC will provide guidance so that we can all work together and make the best decision for the patient.”

Cost considerations and impact
Although the panel raters were instructed to disregard cost in their evaluation of individual tests, controlling costs to patients and the health care system overall was a secondary goal underlying the development of the AUC. “It used to be that the patient never thought about the cost of lab tests,”

Informing the doctor-patient conversation
In 2012, the American Board of Internal Medicine Foundation challenged medical specialty organizations to take a hard look at the necessity of some of the most commonly used tests or procedures in their fields. The resulting initiative, known as the Choosing Wisely® campaign, has attracted more than 70 medical specialty societies (including the AAD), which have published more than 400 recommendations regarding overused tests and treatments that clinicians and patients should discuss. “I felt it was really important to contribute some ASDP recommendations to the Choosing Wisely campaign,” said Claudia I. Vidal, MD, PhD. “It’s a great initiative that really tries to get the conversation going between different groups, not only groups of physicians, but between physicians and patients, to address overuse. I think some of our appropriate use criteria fit really nicely into the Choosing Wisely model.”

Following are five recommendations selected by the ASDP, as they appear on the Choosing Wisely website at www.choosingwisely.org:

- **Do not perform** T-cell receptor (beta and gamma) gene rearrangement studies on inflammatory/reactive lesions or papular/papulonecrotic eruptions when there is clinical and histologic concordance for a diagnosis of pityriasis lichenoides or lymphomatoid papulosis. Although clonality assays such as T-cell receptor beta and gamma studies can be useful in the detection of monoclonality in lymphoproliferative disorders, there are limitations in the sensitivity and specificity of the test. In addition, the test has a high false positive rate, making it unreliable in differentiating between benign inflammatory dermatoses and T-cell lymphoproliferative disorders.

- **Do not perform** diagnostic cytogenic analysis on a lesion from an adult patient when the histopathology is definitive for a melanoma. Histologic examination is currently the gold standard in the diagnosis of melanocytic lesions. Cytogenetic analysis can serve as an adjunct test when a definitive diagnosis cannot be rendered on histologic grounds but should not be used when a diagnosis can be made unequivocally by histologic examination.

- **Do not perform** diagnostic cytogenic analysis on a lesion from an adult patient when the histopathology is definitive for a melanocytic nevus. Histologic examination is currently the gold standard in the diagnosis of melanocytic lesions. Cytogenetic analysis can serve as an adjunct test when a definitive diagnosis cannot be rendered on histologic grounds but should not be used when a diagnosis can be made by histologic examination.

- **Do not perform** the t(17;22) fluorescence in situ hybridization (FISH) assay on cases of dermatofibrosarcoma protuberans in situations where the translocation has already been detected by another testing modality. Various testing modalities can be used to detect the t(17;22) translocation in dermatofibrosarcoma protuberans, with each being able to provide confirmation of the presence of the translocation.

- **Do not perform** the EWSR1 fluorescence in situ hybridization (FISH) assay on cases of clear cell sarcoma in situations where the translocation has already been detected by another testing modality. Various testing modalities can be used to detect the translocation involving EWSR1 gene in clear cell sarcoma, with each being able to confirm the presence or absence of the translocation.
Putting care into context

said Rosalie Elenitsas, MD, professor of dermatology at the University of Pennsylvania’s Perelman School of Medicine and current president of the ASDP. “No matter what laboratory tests were ordered, the cost was almost always covered by insurance, and the patient was not faced with paying the bill. Now that is not the case. People have really high deductibles, and if they have not met their deductible, they will be responsible for the cost of their pathology. We obviously don’t want to underuse our tests and miss a diagnosis, and we don’t want overutilization for multiple reasons, cost being a big one. The cost of health care has really come to the forefront in the last few years, and finding a balance of utilizing health care resources can be a challenge.”

On the other side of the cost equation, the ASDP recognized that government and private payers have a stake in the reduction of unnecessary testing and reimbursement for tests that will lead to accurate diagnoses and effective treatment. As the AUC task force began its work, “we took the approach of trying to involve payers as much as they would allow us to involve them,” said Dr. Vidal. “We included a representative from a regional Medicare carrier as part of the panel rater group in the initial round. She ended up recusing herself to avoid a conflict of interest, but she asked that we send her the final manuscript, so she could then distribute it to regional Medicare carriers.” Dr. Elston added that the rep sent the ASDP a note of approval stating, “that we had done this really well, and she anticipated it would be widely adopted by Medicare and other payers, and that any future similar efforts on our part would be very welcome.”

“AUc evolution

As new tests emerge, and the body of scientific evidence around advanced testing grows, the ASDP plans to supplement and adapt its AUC. To that end, the society changed the task force to a standing committee, now chaired by Dr. Vidal. In addition to spearheading efforts to get the word about the current AUC out to physicians (including participating in a Twitter journal club discussion), she said the committee is meeting regularly to consider the next steps. “First, we’ll be looking to see what new literature has been published since 2016 on tests that we’ve already explored, and then we’ll go back and look to see if the clinical indications for testing have changed. We’re also just beginning the process of discussing what new tests we will start developing AUCs for — which will require approval from the executive committee of the ASDP.” One likely candidate for re-evaluation is the qRT-PCR, Dr. Vidal said. “For qRT-PCR, the ratings were uncertain appropriateness for the majority of clinical scenarios, with the exception of those instances where histology shows a nevus or melanoma. These latter cases were ranked as rarely appropriate to perform the test.” The updates will likely occur in phases, Dr. Vidal remarked, with the earliest targeted for publication in 2020.

While AUC can be viewed as a first step in developing quality measures, it’s important to understand the distinction between the two, Dr. Vidal noted. “Appropriate use criteria are really just guides to help us in test selection for individuals. There’s no metric to be met. It’s really an aid, another tool to have in your pocket.”

Dr. Alam noted that payers are already using AUC as a pathway for showing when Mohs surgery should be covered. “Some of the Medicare contractors in some states have incorporated the Mohs AUC into their local coverage determinations [LCD], and the same sort of thing could happen with the dermpath criteria. Now if you have condition X, for which test Y is appropriate, and you submit that test, the carrier pays for it because they can refer to the LCD.” The ASDP has not reached out to private payers, Dr. Vidal said, but “in general, private payers tend to follow some of the trends that Medicare ends up making: A cut here, an increase there, and the private payers will do something similar.”

Legally speaking


Dr. Alam noted that payers are already using AUC as a pathway for showing when Mohs surgery should be covered. “Some of the Medicare contractors in some states have incorporated the Mohs AUC into their local coverage determinations [LCD], and the same sort of
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Has it really been a year already? There’s something to be said about that old refrain that time flies when you’re having fun. These last 12 months serving as your Academy president have not always been fun, but they have always been challenging and busy. Certainly, this year has also been one of the most rewarding of my career.

There are more than 20,000 physician members across the United States and abroad, and there has been no shortage of work to do with competing needs and priorities. With all the changes, good and bad, going on in health care in our country, our members’ challenges and opportunities are evolving. In some instances, it feels as if the world has shifted 180 degrees in a day. Our Academy is working hard to be proactive in advancing excellence in dermatology in this rapidly changing environment as well as reactive to our members’ needs.

This year, our Academy has made a great effort positioning the specialty as the leader in skin, hair, and nail health expertise. Through the hard work of the AAD’s communications team, there were thousands of media stories featuring dermatologists online, on TV, on the radio, and in print. Additionally, more than 28 million web visitors accessed the AAD’s public education content on aad.org.

We also did yeoman’s work advocating for our patients and our specialty to both state and federal policymakers. From fighting step-therapy requirements at our statehouse, to battling unjustifiable cuts to reimbursement for E/M services billed with modifier 25 at CMS — if there was an issue affecting our patients and our practice, our Academy was there. All of our advocacy work didn’t happen in a Washington, D.C., bubble, however. In 2018, 1,963 Academy members throughout the country contacted their policymakers through the AADA’s Advocacy Action Center, and sent 3,620 letters to Congress, state legislatures, and federal agencies. Many of our colleagues flew to Washington to attend the 2018 AADA Legislative Conference. In just 24 hours, our members participated in 240 meetings with members of Congress or their staff to discuss top-priority health care policy issues.

This year, we also looked inward and developed several tools and resources to help our specialty manage the ever-changing health care environment. DataDerm™ — the Academy’s data registry — helped many of our members easily report for MIPS. More than 1,000 active practices are currently utilizing DataDerm and more than 2,700 providers submitted with DataDerm for MIPS in 2017. No one — I repeat — NO ONE who used DataDerm to report for MIPS in 2017 will see a Medicare penalty, and many users will actually receive a high-performance bonus.

In addition to DataDerm, the AADA’s online Practice Management Center (PMC) has become a go-to member resource for navigating their practice issues. In 2018, 3,400 members used the PMC’s prior authorization letter generator to streamline the process of getting treatments approved for patients, and 1,500 members used the MIPS quality measures tool to help choose which measures to report.

Let’s not forget about our Academy’s educational efforts. This year, 18,856 people attended the AAD’s Annual Meeting in San Diego. At home, almost 10,000 AAD members have put their knowledge to the test with the AAD’s popular ‘Question of the Week’ quizzes for CME credits. The Academy also released updated guidelines of care for melanoma and non-melanoma skin cancer and launched a new JAAD journal club on Facebook. This is simply a sliver of what our Academy has done this year on the educational front.

Finally, the Board recently launched a new strategic plan, where we set a simple, but lofty vision for the Academy: Recognized as the leading authority for the highest quality of compassionate dermatologic care. In striving for this vision, the plan sets goals for the next five years that will focus on excellence in dermatologic care through education and advocacy, access to dermatologic care, data-driven transformation of care, unity of the specialty, and support for board-certified, dermatology-led care teams. We have a lot of work ahead, but I believe the future of the specialty is bright.

I will close with this: You can continue to count on the Academy for support and resources to manage the everyday issues you and your patients face. With George Hruza, MD, MBA, leading the charge, positive progress on our most pressing issues is inevitable. As for me, I may be passing the baton, but I’m still in the race because there is still much to be done.

Thank you for allowing me to serve as your president. It has been a true honor. dw
What is the Academy doing to advocate for appropriate coverage and reimbursement for dermatologic care?

As one of its top advocacy priorities, the AADA continuously advocates for appropriate coverage and reimbursement of dermatologic care.

Advocacy activities:
The AADA consistently advocates for reforms that preserve fee-for-service as a viable option for those specialties and practices that do not fit into current alternative payment models. Additionally, the AADA advocates for policies that ensure patient access to care.

The AADA’s recent advocacy successes include the following:

- The Centers for Medicare and Medicaid Services (CMS) backed away from a concerning proposal that would have made aggressive changes to payment associated with modifier 25 and delayed a proposal to collapse E/M codes.
- Anthem, Inc. rescinded a proposed policy to reduce reimbursement for E/M services billed with a modifier 25 by 50%.
- Congress passed, and President Trump signed into law, legislation that prohibits pharmacy benefit managers (PBMs) and private payers from including gag clauses in contracts with pharmacists that forbid them from telling patients a drug may be cheaper out of pocket rather than going through their insurance. Since 2016, 30 states have enacted laws prohibiting gag clauses.
- 19 states passed laws that protect against step therapy protocols.

Resources for physicians:
The Academy has also developed several resources for physicians to help their patients get the medications and treatments they need. Here are a few highlights:

- Prior authorization assistance tools such as a letter generator and a troubleshooting card for patients.
- Resources and information on how to determine the cost of a prescribed medication and get assistance obtaining a prescription.

Check out these resources and more at www.aad.org/drug-pricing and in the AADA’s Practice Management Center at www.aad.org/priorauth.
OBITUARIES

BY JERRY GRAFF, MD

The Academy recently learned with sorrow of the passing of the following members of the dermatologic community.

ROLLIE S. ACKERMAN, MD, of Northbrook, Illinois, July 31, 2013, at age 65; trained in dermatology at the University of Illinois at Chicago. (No other information available.)

LOUIS LUKE “LUCKY LUKE” BARICH, MD, of Hamilton, Ohio, Jan. 7, 2019, at age 89. Was one of the early founders of the Ohio Dermatology Association (ODA). Served as past president of the ODA and Ohio Dermatology Foundation, and treasurer for many years. Received the Distinguished Dermatologist award from the Ohio Dermatology Association and a volunteerism award from the American Academy of Dermatology. Born in Plum, Pennsylvania, and served in the U.S. Army Infantry as a clerk typist, surgical technician, and petroleum product analyzer. Graduated from University of Pittsburgh Medical School, opened his dermatology office in Hamilton, and practiced for 56 years. Also served as president of the Butler County Medical Society, Hamilton-Fairfield Academy of Medicine, and Butler American Cancer Society. Was a “pioneer in protecting minors from the hazards of ultra-violet radiation emitted from tanning beds.”

JAY G. BARNETT, MD, of New York, Nov. 13, 2018, at age 80; trained in dermatology at NYU and practiced for close to 50 years in Manhattan. Was a pioneer in the use of medical grade liquid silicone, particularly for scars; also helped refine the techniques of hair transplantation; helped develop the specialty of cosmetic dermatology; was an early responder in treating AIDS patients in the ’80s and ’90s; received the President’s Award from the ASDS; practiced with his daughter.

LEONARD W. BUNCH, MD, of Monroe, Louisiana, May 27, 2018, at age 86; planned to become a veterinarian but was convinced to go into medicine; trained in dermatology at LSU Medical Center and practiced in Monroe for many years; was a consummate businessman who was active in oil and gas production, banking, and real estate development; designed and built special homes in Louisiana and Wyoming; opened an antiques and interior design business with his wife in Natchez, Mississippi.

WILLIAM BURROUGHS, MD, of Luling, Louisiana, Aug. 25, 2017, at age 95; trained in dermatology at NY Poly clinic Hospital and Medical School; practiced in Luling for approximately 60 years.

ARTHUR B. KERN, MD, of Pawtucket, Rhode Island, March 6, 2018, at age 97; trained in dermatology at NYU; served in the U.S. Navy in both World War II and the Korean War; practiced in Providence, Rhode Island and was Emeritus Professor of Dermatology at Brown University Medical School; he and his wife were avid collectors of American folk art and, it was said by fellow collectors, that they created the current field of American folk art; they collaborated on 30 papers on the subject in national publications; also was an exhibiting sculptor; was active in local and national politics; loved skiing, tennis, and bird-watching.
ROBERT M. MELNIKOFF, MD, of Los Altos Hills, California, Oct. 29, 2018, at age 85; trained in dermatology at Stanford and practiced in Mountain View, California for almost 60 years; was Emeritus Adjunct Clinical Professor of Dermatology at Stanford.

WILLIAM C. MILLER, MD, of Middleton, Wisconsin, Oct. 25, 2018, at age 99, one month short of his 100th; he seems to have trained in dermatology at Northwestern University, University of Chicago, University of Michigan, and University of Wisconsin in various “resident teaching” positions; practiced in Wausau, Wisconsin and, after “retirement” in Madison, Wisconsin; characterized by one of his children as a story teller, poet, artist, adventurer, whistler, and singer.

VIC NARURKAR, MD, of San Francisco, January 2019, at age 50. Graduated from Brown University and attended Stanford University medical school. Completed dermatology residency at Stanford and was selected chief resident. Completed fellowships in Mohs surgery and laser and cosmetic dermatologic surgery at the Cleveland Clinic. Contributed to development of pulsed dye and alexandrite lasers for birthmark and tattoo removal. Was appointed as the director of dermatology and assistant professor at UC Davis Laser Center, “where he was the original investigator for laser hair reduction with alexandrite and diode lasers, pulsed dye and KTP lasers for port cosmetic vascular lesions and skin resurfacing with CO2 lasers.” Established the Bay Area Laser Institute and simultaneously joined the practice of Kathy Fields, MD, co-founder of ProActiv solution. In 2009, was appointed chair of dermatology at California Pacific Medical Center. Was a former ASDS board member, past president of the American Society of Cosmetic Dermatology and Aesthetic Surgery, and co-director of the Cosmetic Boot Camp, LLC. Served on the JAAD editorial board.

NORMAN ORENTREICH, MD, of New York City, Jan. 23, 2019, at age 96. Trained in dermatology at NYU Medical Center. Was the founding dermatologist for Clinique. In 1952, performed the world’s first hair transplant to treat male pattern baldness. Founded Orentreich Medical Group in New York City in 1956. Elected the first and second president of the American Society for Dermatologic Surgery. 

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.
PROFESSIONAL OPPORTUNITIES

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Email: cparratt@aad.org

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PROFESSIONAL OPPORTUNITIES

Director, Mohs Surgery and Procedural Dermatology

Brown Dermatology is recruiting a full-time Director, Mohs Surgery and Procedural Dermatology. Candidates must be board eligible/board certified in Dermatology and have completed a fellowship in Mohs micrographic surgery. Academic appointment will be at the Department of Dermatology at the Warren Alpert Medical School of Brown University as Assistant Professor, Associate Professor, or Professor. Greater than five years’ experience post-fellowship is preferred. The Director will help set the vision for growth, manage the operations of an expanding procedural service and spearhead recruitment of outstanding faculty to meet the ever-growing needs of our patients in Rhode Island, Southern Massachusetts and Northern Connecticut. In addition, the Director will participate in resident teaching and training and oversee the procedural curriculum for the Brown Dermatology Residency Training Program. Brown Dermatology performs a high volume of cases annually at our main academic center in Providence as well as in beautiful new sites in several locations across the State of Rhode Island. We seek enthusiastic procedural dermatologists looking to build or further the careers in an academic and supportive environment!

Located in Providence, the historic ‘creative capital’ of Rhode Island, Brown University was founded in 1764 and is an Ivy League university offering a world class college, graduate school, medical school, school of public health, and school of engineering. Brown Dermatology provides high quality general and procedural dermatology services to several area hospitals within Lifespan (Rhode Island Hospital, The Miriam Hospital, Hasbro Children’s Hospital) and in other large systems, including Care New England (Memorial Hospital, Women & Infants Hospital and Kent Hospital) and the Providence VA Medical Center.

Interested candidates should send a brief letter of interest and curriculum vitae to Abrar A. Qureshi, MD, MPH, Professor and Chairman, Department of Dermatology, Warren Alpert Medical School and Rhode Island Hospital/Miriam Hospital via kate_lada@brown.edu.

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A Publication of the American Academy of Dermatology | Association
DERMATOLOGY WORLD // March 2019 55
While the future of American health insurance remains a question mark, data from the 2017 AAD Practice Profile Survey has helped shed light on where reimbursement trends might be headed. Although the percentage of patients with private fee-for-service coverage has remained relatively consistent since 2014, traditional Medicare has declined by 6%. More troublingly, survey data also indicate that 39% of treatment plans are being altered due to insurance — a sizeable 10% jump from 2014 that suggests an increasingly difficult relationship with insurance companies. For a more complete picture of changes in reimbursement sources, see the chart below.

### Average percentage of patients by payer source

<table>
<thead>
<tr>
<th>2014</th>
<th>2017</th>
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<td>30%</td>
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<td>14%</td>
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<tr>
<td>33%</td>
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**KEY**
- Green: Private fee for service
- Purple: Self-pay cosmetic
- Orange: Traditional Medicare
- Gray: Medicaid
- Red: Managed Medicare HMO
- Teal: Self-pay medical and surgical
- Black: Tricare
- Blue: Other
There is a lot of valuable information covered at the 2019 AAD Annual Meeting, from ground-breaking research to the latest in patient care. Catch sessions you miss and review your favorites with 2019 Annual Meeting On-Demand Recordings.

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