Data illuminates path to continued viability

Dermatology practices look to benchmarking to protect finances as health system evolves

A Publication of the American Academy of Dermatology Association  •  www.aad.org
Navigating Practice, Policy, and Patient Care

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This month I am happy to report...

That my son has returned from Delhi, India. When planning for his semester abroad he was anticipating excitement and adventure, seeing a country both foreign, and yet so engaging. Well he (and therefore me) got more than we bargained for...a bout of Dengue fever, so I’m sure that you all can understand my happiness with getting him back home to the U.S. Despite the sleepless nights his illness caused, when people would ask if I was sorry that he had traveled so far, the answer had to be no. The world truly has become much smaller and the young understand that boundaries that would have held me back and kept me closer to the familiar no longer apply. I also see it in my residents. When government rulings limit what unsupervised residents can do in the U.S., they realize that experiences await them if they are willing to travel to Botswana...and travel they do. Don’t think that would have occurred to me when I was in training...heading up to the New England Derm meetings in Boston seemed like an adventure back then. The magnitude of the cultural change is striking; the very definition of the dermatologic community at large has shifted.

Our column this month on international dermatology describes another country as exotic to many of us as India: China. For so long much of what has been happening in Chinese medicine has been out of sight and unknown. However, just as China has opened its economy to the world, its medical community is also embracing the west. In just a few short years the Chinese have “leap-frogged” to having papers submitted to Western journals — talk about a transformation! I thought it was interesting to understand the role of the SARS epidemic in motivating some of these changes. It seems to me that there have been bumps in the road in their steps to modernize, but it is heartening to see the efforts at providing care for the billions that call China home. Imagine, though, the idea of paying the equivalent of eight dollars annually to cover your health insurance!

Improving the care of patients is not unique to the Chinese. The time has come for us all to benchmark our practices to achieve higher quality of care, yet remain in business. Sound overwhelming? There is no denying it; if you don’t know your own practice’s stats you will be at a grave disadvantage in negotiating with insurers since they have been keeping track of each of our practice patterns for years. EHRs certainly help since they can help us investigate our own coding profiles, insurance denial rates, etc. With ACOs up and running in parts of this country, knowing the true cost of doing business is critical to being able to not sell your practice down the river. I think this is a definite must-read this month.

Another feature this month that you’ll want to be sure to read is the one on the Choos-Wising campaign, a brainchild of the American Board of Internal Medicine Foundation. They teamed up with Consumer Reports to educate the public about wasteful medical tests and practices. Almost all of the medical specialty societies have now joined the effort, including our Academy. Who would have thought that the magazine that guided my purchase of a new wall oven now is going to publicize “outlying” dermatologic decision-making? We truly are entering a new phase in the dermatologic community. So read up about the ways to save health care dollars in the derm arena to make sure that you are not caught in the public’s crosshairs needlessly.

Hopefully each of you will enjoy this month’s issue of DW despite the pressing and competing demands of the holidays. Much cooking and buying of gifts awaits me, too. Our gift to each of you is the feature on the greats in dermatology. We all should be thankful that we can stand on their shoulders to practice dermatology as we know it, care of their insights. Hope that you enjoy learning more about them. Wishing each of you a happy and healthy holiday!

Enjoy your reading.

Abby S. Van Voorhees, MD, Physician Editor

Dear Readers,

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that my son has returned from Delhi, India. When planning for his semester abroad he was anticipating excitement and adventure, seeing a country both foreign, and yet so engaging. Well he (and therefore me) got more than we bargained for...a bout of Dengue fever, so I’m sure that you all can understand my happiness with getting him back home to the U.S. Despite the sleepless nights his illness caused, when people would ask if I was sorry that he had traveled so far, the answer had to be no. The world truly has become much smaller and the young understand that boundaries that would have held me back and kept me closer to the familiar no longer apply. I also see it in my residents. When government rulings limit what unsupervised residents can do in the U.S., they realize that experiences await them if they are willing to travel to Botswana...and travel they do. Don’t think that would have occurred to me when I was in training...heading up to the New England Derm meetings in Boston seemed like an adventure back then. The magnitude of the cultural change is striking; the very definition of the dermatologic community at large has shifted.

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Abby S. Van Voorhees, MD, Physician Editor
“Using benchmarking gives you a report card as to where you stand and where you can enhance your cost structure.”

features

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Celebrating 75 years of growth and change.
Discover a tazarotene treatment that can help quiet moderate to severe acne.

Don’t let acne have the final word.

FABIOR Foam is the only retinoid in a topical foam formulation for acne vulgaris in patients aged 12 years or older.

**Efficacy in moderate to severe acne vulgaris**
- Patients using FABIOR Foam (N=744) and vehicle foam (N=741)
- Significant reduction in inflammatory (FABIOR Foam 56%, vehicle foam 45.3%), noninflammatory (55.9%, 37.7%), and total lesions (53.1%, 40.8%) at week 12 (P<0.001 for all)
- Significantly more patients using FABIOR Foam (28.2%) vs vehicle foam (14.7%) were "clear" or "almost clear" with at least a 2-grade improvement at week 12 (P<0.001)

**Tolerability demonstrated in pivotal studies for FABIOR Foam**
- Percentage of patients with any treatment-related adverse reaction (AR): 22%
- Individual application site ARs ≥1%: irritation (14%), dryness (7%), erythema (6%), exfoliation (6%), pain (1%), photosensitivity (1%), pruritus (1%), and dermatitis (1%)
- Local skin reactions (dryness, erythema, peeling, burning/stinging, and itching) peaked at week 2 and gradually reduced thereafter with continued use of FABIOR Foam
- Less than 3% (20/744) of patients discontinued due to local skin reactions
- Percentage of patients with severe ARs: 3%

**Vehicle**
- Aqueous-based foam formulation that does not contain parabens or alcohol

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**Important Safety Information**

- FABIOR Foam is contraindicated in pregnancy because tazarotene is a teratogenic substance. FABIOR Foam may cause fetal harm when administered to a pregnant woman. If the patient becomes pregnant while using this drug, treatment should be discontinued and the patient apprised of the potential hazard to the fetus
- Females of child-bearing potential should be warned of the potential risk and use adequate birth-control measures to avoid pregnancy. A negative serum or urine result for pregnancy test should be obtained within 2 weeks prior to therapy with FABIOR Foam; therapy should begin during a normal menstrual period
- FABIOR Foam should be used with caution in patients with a history of local tolerability reactions or local hypersensitivity. Retinoids should not be used on abraded or eczematous skin, as they may cause severe irritation. Contact with the mouth, eyes, and mucous membranes should be avoided. Weather extremes, such as wind or cold, may be more irritating to patients using FABIOR Foam. Excessive topical application of FABIOR Foam may lead to marked redness, peeling, or discomfort
- FABIOR Foam may cause skin redness, peeling, burning, or excessive pruritus. Concomitant topical acne therapy should be used with caution because a cumulative irritant effect may occur. If skin irritation occurs, therapy with FABIOR Foam should be reduced to an interval the patient can tolerate, temporarily interrupted, or discontinued. In addition, concomitant dermatologic medications and cosmetics that have a strong drying effect should be avoided
- Because of heightened burning susceptibility, exposure to sunlight (including sunlamps) should be avoided when using FABIOR Foam. Patients must be warned to use sunscreens and protective clothing. Patients with sunburn should be advised not to use FABIOR Foam until fully recovered. Patients who may have considerable sun exposure due to their occupation and those patients with inherent sensitivity to sunlight should exercise particular caution. FABIOR Foam should be used with caution in patients with a personal or family history of skin cancer or if the patient is also taking drugs known to be photosensitizers
- The propellant in FABIOR Foam is flammable. Instruct the patient to avoid fire, flame, and/or smoking during and immediately following application
- Adverse reactions reported in ≥6% of patients treated with FABIOR Foam vs vehicle foam were application site reactions including irritation (14%, 1%), dryness (7%, 1%), erythema (6%, <1%), and exfoliation (6%, <1%). Adverse reactions reported in <1% of patients treated with FABIOR Foam vs vehicle foam were application site reactions including pain (1%), photosensitivity, including sunburn (1%, <1%); pruritus (1%, <1%); and dermatitis (1%, <1%). Adverse reactions reported in <1% of patients treated with FABIOR Foam included application site reactions (including discoloration, discomfort, edema, rash and swelling), dermatitis, impetigo, and pruritus. During the 12 weeks of treatment, local skin reactions (dryness, erythema, peeling, burning/stinging, and itching) peaked at week 2 and gradually reduced thereafter with the continued use of FABIOR Foam
- FABIOR Foam has not been studied in women who are lactating, and it is not known whether this drug is excreted in human milk. A decision should be made whether to discontinue breastfeeding or to discontinue FABIOR Foam
- The safety and effectiveness of FABIOR Foam in pediatric patients under 12 years of age have not been established

Please see brief summary of full Prescribing Information on the following pages.

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FABIOR is a trademark of GlaxoSmithKline, used under license by Stiefel Laboratories, Inc.
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FABIOR™ (tazarotene) Foam, 0.1%  
The following is a brief summary only; see full prescribing information for complete product information.

INDICATIONS AND USAGE: Fabior (tazarotene) Foam, 0.1% is indicated for the topical treatment of acne vulgaris in patients 12 years of age or older.

CONTRAINDICATIONS: Fabior Foam is contraindicated in pregnancy. Fabior Foam may cause fetal harm when administered to a pregnant woman. Tazarotene elicits teratogenic and developmental effects associated with retinoids after topical or systemic administration in rats and rabbits [see Use in Specific Populations].

If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, treatment should be discontinued and the patient apprised of the potential hazard to the fetus [see Warnings and Precautions and Use in Specific Populations].

WARNINGS AND PRECAUTIONS:

Fetal Risk: Systemic exposure to tazarotenic acid is dependent upon the extent of the body surface area treated. In patients treated topically over sufficient body surface area, exposure could be in the same order of magnitude as in orally treated animals. Tazarotene is a teratogenic substance, and it is not known what level of exposure is required for teratogenicity in humans [see Clinical Pharmacology (12) of full prescribing information].

There were five reported pregnancies in patients who participated in clinical trials for topical tazarotene foam. One of the patients was found to have been treated with topical tazarotene for 25 days, two were treated with vehicle foam and the other two did not receive either tazarotene foam or vehicle foam. The patients were discontinued from the trials when their pregnancy was reported. The one pregnant woman who was inadvertently exposed to topical tazarotene during the clinical trial delivered a full-term healthy infant.

Females of Childbearing Potential: Females of child-bearing potential should be warned of the potential risk and use adequate birth-control measures when tazarotene foam is used. The possibility of pregnancy should be considered in females of child-bearing potential at the time of institution of therapy.

A negative serum or urine result for pregnancy test having a sensitivity down to at least 25 mIU/mL for human chorionic gonadotropin (hCG) should be obtained for pregnancy test having a sensitivity down to at least 25 mIU/mL for human chorionic gonadotropin (hCG) should be obtained within 2 weeks prior to Fabior Foam therapy, which should begin during a normal menstrual period, for females of childbearing potential. Advise patients of the need to use an effective method of contraception to avoid pregnancy [see Use in Specific Populations].

Local Irritation: Fabior Foam should be used with caution in patients with a history of local tolerability reactions or local hypersensitivity. Retinoids should not be used on abraded or eczematous skin, as they may cause severe irritation. Contact with the mouth, eyes, and mucous membranes should be avoided. In case of accidental contact, rinse well with water.

Some individuals may experience skin redness, peeling, burning or excessive pruritus. If these effects occur, the medication should either be discontinued until the integrity of the skin is restored, or the dosage should be reduced to an interval the patient can tolerate. However, efficacy at reduced frequency of application has not been established.

Weather extremes, such as wind or cold, may be more irritating to patients using Fabior Foam. Concomitant use with oxidizing agents, such as benzoyl peroxide, may cause photosensitivity. If these effects occur, the medication should either be discontinued until the effects are fully recovered. Patients with sunburn should be advised not to use Fabior Foam until fully recovered. Patients who may have considerable sun exposure due to their occupation and those patients with inherent sensitivity to sunlight should exercise particular caution when using Fabior Foam and ensure that the precautions are observed [see FDA-approved patient labeling of full prescribing information].

Due to the potential for photosensitivity resulting in greater risk for sunburn, Fabior Foam should be used with caution in patients with a personal or family history of skin cancer.

Fabior Foam should be administered with caution if the patient is also taking drugs known to be photosensitizers (e.g., thiazides, tetracyclines, fluoroquinolones, phenothiazines, sulfonamides) because of the increased possibility of augmented photosensitivity.

Flammability: The propellant in Fabior Foam is flammable. Instruct the patient to avoid fire, flame, and/or smoking during and immediately following application.

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

The safety data reflect exposure to Fabior Foam in 744 patients with acne vulgaris. Patients were 12 years to 45 years of age and were treated once daily in the evening for 12 weeks. Adverse reactions reported in ≥ 1% of patients treated with Fabior Foam are presented in Table 1. Most adverse reactions were mild to moderate in severity. Severe adverse reactions represented 3.0% of the patients treated. Overall, 2.6% (20/744) of patients discontinued Fabior Foam because of local skin reactions.

Table 1: Incidence of Adverse Reactions in ≥ 1% of Patients Treated with Fabior Foam

<table>
<thead>
<tr>
<th></th>
<th>Fabior Foam</th>
<th>Vehicle Foam</th>
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</thead>
<tbody>
<tr>
<td>Patients with any adverse reaction, n (%)</td>
<td>163 (22)</td>
<td>193 (26)</td>
</tr>
<tr>
<td>Application site irritation</td>
<td>107 (14)</td>
<td>9 (1)</td>
</tr>
<tr>
<td>Application site dryness</td>
<td>50 (7)</td>
<td>6 (1)</td>
</tr>
<tr>
<td>Application site erythema</td>
<td>49 (6)</td>
<td>3 (&lt;1)</td>
</tr>
<tr>
<td>Application site exfoliation</td>
<td>44 (6)</td>
<td>3 (&lt;1)</td>
</tr>
<tr>
<td>Application site pain</td>
<td>9 (1)</td>
<td>0</td>
</tr>
<tr>
<td>Application site photosensitivity (including sunburn)</td>
<td>8 (1)</td>
<td>3 (&lt;1)</td>
</tr>
<tr>
<td>Application site pruritus</td>
<td>7 (1)</td>
<td>3 (&lt;1)</td>
</tr>
<tr>
<td>Application site dermatitis</td>
<td>6 (1)</td>
<td>1 (&lt;1)</td>
</tr>
</tbody>
</table>

Additional adverse reactions that were reported in < 1% of patients treated with Fabior Foam included application site reactions (including discoloration, discomfort, edema, rash and swelling), dermatitis, impetigo and pruritus.

Local skin reactions, dryness, erythema, and peeling actively assessed by the investigator and burning/tingling and itching reported by the patient were evaluated at baseline, during treatment, and end of treatment. During the 12 weeks of treatment, each local skin reaction peaked at week 2 and gradually reduced thereafter with the continued use of Fabior Foam.

DRUG INTERACTIONS: No formal drug-drug interaction studies were conducted with Fabior Foam.

Concomitant dermato logical medications and cosmetics that have a strong drying effect should be avoided. It is recommended to postpone treatment until the effects of these products subside before use of Fabior Foam is started.

Concomitant use with oxidizing agents, such as benzoyl peroxide, may cause photosensitivity. If these effects occur, the medication should either be discontinued until the effects are fully recovered. Patients with sunburn should be advised not to use Fabior Foam until fully recovered. Patients who may have considerable sun exposure due to their occupation and those patients with inherent sensitivity to sunlight should exercise particular caution when using Fabior Foam and ensure that the precautions are observed [see FDA-approved patient labeling of full prescribing information]. Due to the potential for photosensitivity resulting in greater risk for sunburn, Fabior Foam should be used with caution in patients with a personal or family history of skin cancer.

In rats, tazarotene 0.05% gel administered topically during gestation days 6 through 17 at 0.25 mg/kg/day resulted in reduced fetal body weights and reduced skeletal ossification. Rabbits dosed topically with 0.25 mg/kg/day tazarotene gel during gestation days 6 through 18 were noted with single incidences of known retinoid malformations, including spina bifida, hydrocephaly, and heart anomalies.

Systemic exposure (AUC) to tazarotenic acid at topical doses of 0.25 mg/kg/day tazarotene in a gel formulation in rats and rabbits were 15 and 166 times, respectively, the systemic exposure (AUC) in acne patients treated with 2 mg/cm² of Fabior Foam 0.1% over a 15% body surface area.

As with other retinoids, when tazarotene was administered orally to experimental animals, developmental delays were seen in rats, and teratogenic effects and post-implantation loss were observed in rats and rabbits at doses 13 and 325 times, respectively, the systemic exposure (AUC) to tazarotenic acid in acne patients treated with 2 mg/cm² of Fabior Foam 0.1% over a 15% body surface area.

In female rats orally administered 2 mg/kg/day tazarotene from 15 days before mating through gestation day 7, a number of classic developmental effects of retinoids were observed including decreased number of implantation sites, (cont’d on next page)
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“An ACO just called...”
“The auditors are coming...”
“I need to hire a new receptionist...”

You’ve read all about these issues in Dermatology World. Now, you can find the information you remember reading right when you need it — without digging through all of your old copies. Visit www.aad.org/dw and use the “Search Dermatology World” box. The help you need is a click away!
The National Correct Coding Initiative (NCCI) is a set of Medicare guidelines developed and implemented for the purpose of ensuring optimal Medicare-approved coding and billing for medical services. Many private insurers also follow the NCCI edicts. The NCCI consists of three principal components, all of which are available on the Web: the National Correct Coding Initiative Policy Manual for Medicare Services, the NCCI Code Pair Edits, and the Medically Unlikely Edits. Each of these facets of the NCCI contains information that is essential for proper Medicare billing and reimbursement. The Policy Manual explicitly describes various Medicare billing requirements and restrictions, including the uses and limitations of Current Procedural Terminology (CPT) modifiers. The Code Pair Edits is a list of paired CPT codes that determines whether both of two paired CPT codes are potentially payable if an appropriate modifier is used, and which of the two codes should receive the modifier. The Medically Unlikely Edits (MUEs) is a list of the usual maximally allowable units of service for a single CPT code billed for a single patient encounter. A reader-friendly explanation of the NCCI is available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How-to-Use-NCCI-Tools.pdf.

The following are several case scenarios with billing explanations based upon the NCCI guidelines.

Case 1: Your Medicare patient has a broad suspected lentigo maligna on her face. In order to assess for histologic variability within the lesion you biopsy, separately identify, and submit in separate containers for histopathologic evaluation three sites: superior, middle, and inferior. Do you bill for three separate biopsies, 11100 and 11101x2, or is your billing limited to one biopsy charge?

Answer: The National Correct Coding Initiative Policy Manual for Medicare Services (available at www.cms.gov/nationalcorrectcodinginit/) specifies that a single lesion biopsied multiple times may only be billed as one biopsy charge: “If a single lesion is biopsied multiple times, only one biopsy code may be reported with a single unit of service.” The appropriate charge for the above scenario is 11100, nothing more.

Case 2: You have received for histopathologic interpretation three separately identified and processed specimens from the suspected lentigo maligna in Case 1. Three separate blocks, three separate tissue slides, and three separate interpretations and diagnoses are generated. Do you bill as you would for the biopsy, with one charge, or are you entitled to seek reimbursement for the three separate interpretations?

Answer: The NCCI document reads: “If it is medically reasonable and necessary to submit multiple biopsies of the same or different lesions for separate pathologic examination, the medical record must identify the precise location and separate nature of each biopsy.” Conclusion: you may bill for three separate 88305 or 88305-26 pathology charges. However, as the biopsies are all from the same location, they may, depending upon your diagnostic interpretation, all receive an identical ICD-9 diagnosis. Your claim for the second and third lesion interpretations, based upon a recent CMS missive, is then likely to be rejected as a duplicate; see www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2678CP.pdf.

What now? The NCCI indicates that the interpretations beyond the first should...
be billed with modifier 91, “repeat clinical diagnostic test”. Thus, for three specimens the billing may be: 88305, 88305-91 and 88305-91 or 88305-26, 88305-26-91 and 88305-26-91. In the “Notes” section of the CMS1500 form it is helpful to specify the distinct locations of each biopsy. Individual Medicare contractors and private insurers may handle this situation in their own peculiar fashion. Some insurers will not recognize modifier 91 and automatically reject any such claim and may pay it only following a written appeal. Check with your local carriers to familiarize yourself with their policy.

**Case 3:** You remove two facial nevi tangentially for cosmetic reasons. You ink one specimen and submit both in one container for histopathologic evaluation. Does one then bill for two 88305 interpretations, as there are two specimens being evaluated, or one, because both specimens are processed in one block and presented together on a slide?

**Answer:** The NCCI clarifies this by stating: “If multiple lesions are submitted for pathological examination as a single specimen, only one CPT code may be reported for examination of all the lesions even if each lesion is processed separately.” Consequently, appropriate billing is one 88305 or 88305-26 charge.

**Case 4:** A patient comes to you for evaluation of a skin tumor treatment. He brings along a copy of a pathology report and the original slides for your review. You evaluate the patient and interpret the biopsy slide tissue. You bill 99203 for the initial patient visit along with 88321, “consultation and report on referred slides prepared elsewhere.” Is that correct?

**Answer:** That is incorrect. The NCCI states: “CPT codes 88321-88325 should not be reported with a face-to-face evaluation of a patient. If a physician provides an evaluation and management (E/M) service to a patient, and, in the course of the E/M service, specimens obtained elsewhere are reviewed as well, this review is part of the E/M’s medical decision making service and is not reported separately. Only the E/M service should be reported.” You may only bill the 99203 E/M service.

**Case 5:** You excise a large, abscessed epidermoid cyst from the back of a Medicare patient. Seven days later the patient returns with a fluctuant, liquefied hematoma, which you aspirate. Do you charge for CPT 10160, puncture aspiration of hematoma?

**Answer:** No charge is warranted. The hematoma and its in-office treatment occurred during the 10 day global period for the minor excision surgical procedure. The NCCI states: “...the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment.” Check with your carriers to familiarize yourself with their policy on billing for complications.

**Case 6:** You schedule a new patient traveling a long distance for possible Mohs surgical excision of a basal cell carcinoma located on the nose. After evaluating the patient, examining the nose along with sun-damaged skin elsewhere, you determine appropriateness for Mohs surgery. You excise the tumor with one stage of Mohs surgery and repair the defect with an advancement flap. Since you performed an initial patient evaluation, determined the need for surgery, and then did the surgery, may you bill and qualify for payment for an initial new patient evaluation, 99202 or 99203 in addition to the surgery?

**Answer:** The NCCI reads: “If an E/M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E/M service is separately reportable with modifier 57.” Thus, the initial visit would be reported as CPT 99202-57 or 99203-57 in addition to the surgery charges, as the flap repair (adjacent tissue rearrangement) is a “major,” 90-day global procedure. dw
Dermatologists and allied advocates saw measurable gains as a result of their legislative advocacy in 2013. Whether addressing the future of physician-led team care or leading the push against tanning beds, dermatologists successfully educated both legislators and the public on a number of public health issues, changing opinions and laws nationwide as a result.

**INDOOR TANNING**

Physicians and advocates dedicated to pushing the issue of restricting tanning bed use among minors can claim a number of tangible successes in 2013 to add to the growing list of victories over recent years. Illinois, Nevada, Oregon, and Texas all passed bills to prevent minors under 18 from using tanning beds. The Illinois bill was the latest in an anti-tanning push in the state that saw both Chicago and state capital Springfield ban underage tanning in 2012.

This legislation brings to 40 the number of states (including the District of Columbia) that regulate the use of indoor tanning devices for minors in some way. The 10 states that do not regulate tanning include Alaska, Hawaii, Idaho, Missouri, Montana, Nebraska, New Mexico, Oklahoma, South Dakota, and Washington.

**TRUTH IN ADVERTISING**

Four states — Maine, Maryland, Texas, and Nevada — addressed the issue of truth in advertising with bills that prevent patient confusion over the identification of physician and non-physician personnel in a practice or hospital. All four of the states used legislative language based on the American Medical Association’s model bill. The new laws require clear disclosure and display of credentials for any employee within a health care setting, including their position and type of license.

These states bring the number of states that have enacted some form of truth in advertising legislation to 14, including Arizona, California, Connecticut, Florida, Mississippi, New Hampshire, Oklahoma, Oregon, Pennsylvania, and Utah.

**SCOPE OF PRACTICE**

Bills aimed at expanding scope of practice for non-physician personnel were defeated in both the Illinois and California legislatures in 2013. Illinois rejected a move to extend more privileges to physician assistants. The California legislature heard bills to expand the non-supervised scope of practice for nurse practitioners and optometrists. The American Academy of Dermatology Association and other members of the AMA’s Scope of Practice Partnership opposed both bills.

**BIOSIMILARS**

The nation’s first biosimilar substitution bill was passed in April 2013, with Virginia legislators approving a measure that would require a biosimilar to be dispensed in place of the original prescribed product only if the FDA has declared the products to be interchangeable. Further, the prescribing physician must be notified within five days, and can veto the substitution. Both the pharmacist and prescriber must keep a running two-year record of substitutions in case there are adverse events.

Shortly after, both North Dakota and Utah’s governors signed bills into law addressing the substitution of biosimilars. The North Dakota law requires a notification to the prescriber within 24 hours and a five-year record keeping period. The Utah legislation requires pharmacy staff to counsel patients on the use of biologics, and holds out-of-state pharmacies that supply biosimilars to the state to the same provisions as in-state pharmacies. – JOHN CARRUTHERS
FDA warns of hepatitis B risk for common CTCL treatments

TWO DRUGS THAT ARE USED TO TREAT cutaneous T-cell lymphomas raise the risk of reactivation of a hepatitis B virus (HBV) infection, according to the Food and Drug Administration (FDA). The agency added new warning information to the labels of ofatumumab (marketed as Arzerra) and rituximab (marketed as Rituxan) on Sept. 25. It warns that, in patients with a prior HBV infection, even one that has been clinically resolved, the immune impairment caused by both drugs could lead to reactivation, which could cause liver failure and death.

As a result, the FDA recommends that all patients be screened for HBV infection before they start taking either drug. More information about how to do so, and about steps to take with patients who are at risk of reactivation, is available on the FDA website at www.fda.gov/Drugs/DrugSafety/ucm166406.htm. - RICHARD NELSON

Deadline to report PQRS measures for 2013 is Jan. 17, 2014

DERMATOLOGISTS AND NON-PHYSICIAN clinicians who report quality measures to Medicare’s Physician Quality Reporting System (PQRS) during the 2014 reporting period will make themselves eligible for a bonus payment of 0.5 percent of their total Medicare Part B allowed charges. In addition to qualifying for the incentive, reporting PQRS measures for 2014 will help dermatologists avoid a 2 percent payment reduction to be assessed in 2016. 2014 is the last year of scheduled incentive payments; the 2 percent payment reduction for not reporting will continue beyond 2016.

Based on Medicare’s proposed fee schedule, dermatologists in 2014 will have to report on nine measures in order to make themselves eligible for a bonus payment and avoid the payment reduction in 2016. (The AADA and other medical societies suggested reducing the number of measures that must be reported; the final rule that will reflect whether this suggestion was accepted had not been published at press time.) The 2014 program will include dermatology-appropriate measures related to melanoma, biopsy follow-up, atopic dermatitis, and psoriasis.

There is still time to participate in the 2013 PQRS through the AAD registry; those who report for 2013 can earn a bonus payment of up to 0.5 percent and potentially avoid a payment reduction in 2015. Those still wishing to participate will have until Dec. 13, 2013 to purchase the registry and until Jan. 17, 2014 to enter and submit all of the information. More information about the measures for 2013 and 2014 and on purchasing the 2013 Physician Quality Reporting System Melanoma Reporting module is available at www.aad.org/education/performance-measurement-and-quality-reporting/medicare-physician-quality-reporting-system. - SCOTT WEINBERG

Member responds to reimbursement recommendation

I READ WITH GREAT INTEREST the opinion of Robert Swerlick, MD, in September’s Dermatology World (www.aad.org/dw/monthly/2013/september/shifting-sands) regarding how dermatologists should approach upcoming changes in health care.

Specifically, I disagree with Dr. Swerlick’s opinion that we should provide high quality care at lower cost. High quality, yes, but practicing dermatologists cannot continue with lower and lower reimbursements. Use of the term value depends on who is defining it. The bean counters mean less reimbursement. Dermatologists mean high quality care and reasonable reimbursement.

We must fight on a state and national level to stop erosion of what we are paid for our services. Dr. Swerlick’s assumption is that our fees are too high. To counter this, the AADA needs to expend more resources to show that we do deliver high quality and value. Our fees are reasonable — we should not bow to reductions in reimbursement.

Ray Cornelison, MD
Oklahoma City

Dermatology World welcomes submissions to the “Other Voices” column from members of the American Academy of Dermatology. Submissions should respond directly to content presented in the magazine and are limited to 250 words. DW’s editorial team reserves the right to accept or reject submissions and to edit submissions prior to publication. A response from the editor may be added if applicable.

- SCOTT WEINBERG
Study demonstrates sunscreen’s ability to protect against skin aging

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Adele Green, MB BS, PhD, MSc, about her recent Annals of Internal Medicine article, “Sunscreen and Prevention of Skin Aging.”

Q&A

DR. VAN VOORHEES: Getting patients to use sunscreens is always a challenge and the fear of possible skin cancer is often not enough to get people to protect their skin in the sun. When I saw your paper about the potential role of sunscreens in the prevention of aging of the skin it caught my attention since most patients truly care about how their skin looks. What has been known up until this point?

GREEN: It has long been known that most skin aging changes are due to photoaging after cumulative sun exposure, superimposed on chronological aging. Many topical anti-aging agents have been promoted as being efficacious, including sunscreen, but there was no evidence that sunscreen can actually protect against skin aging apart from in experimental animals.

DR. VAN VOORHEES: Many people believe that beta carotene has photoprotective properties. Is this why you studied this agent as well? How strong was the prior literature demonstrating its effectiveness at preventing photoaging?

GREEN: Again, there had been only experimental evidence [in animals] that oral antioxidants can reduce signs of oxidative skin damage and wrinkling due to sun exposure; there was no strong evidence that this applied to humans. At the time we started this trial, epidemiological evidence suggested that people whose diets were rich in beta-carotene were less likely to develop certain epithelial cancers. Putting both of these together, we wished to test the hypothesis that the antioxidant properties of beta carotene protected against both the development of skin cancer and the progression of photoaging.
**DR. VAN VOORHEES:** Tell us about your study design. How were patients randomized to the various study groups? Where there any differences in the amount of sun exposure that the various groups received over the time that this was being studied?

**GREEN:** Participants were not patients of a clinic; rather, they were randomly selected adult residents of the Queensland, Australia, township of Nambour aged under 55. Using a computer-generated randomized list, they were allocated to daily application of sunscreen labeled Sun Protection Factor (SPF) 15+ and broad-spectrum or discretionary sunscreen use (placebo sunscreen was considered unethical); and independently, to 30mg beta-carotene or placebo supplements daily. Those allocated to daily sunscreen were asked to apply the intervention sunscreen to head, neck, arms, and hands every morning, with reapplication after heavy sweating, bathing, or spending more than a few hours outdoors while the control group were not given any instructions regarding sunscreen use.

Reported sun exposure was similar between the daily and discretionary sunscreen groups during the trial (around three-quarters of both groups spent less than 50 percent of weekend time outdoors) and use of other sun protection measures like seeking shade and wearing a hat was almost the same in both treatment groups.

**DR. VAN VOORHEES:** What did you find as a consequence of your investigation? Did either sunscreens or beta carotene demonstrate benefit in the prevention of photoaging? Was there a difference if sunscreens were used daily versus more intermittently?

**GREEN:** The group that were allocated to using sunscreen regularly showed 24 percent less photoaging than the group who used sunscreen only some of the time if at all; in fact the sunscreen group showed no detectable increase in aging during the trial period. (The trial was analyzed according to treatment allocation to preserve the balance of confounding factors achieved by randomization, rather than according to amount of sunscreen used, when one would lose the benefits of random allocation.) Beta-carotene supplementation had no effect on skin aging overall, though we saw contrasting associations in those with less severe versus more severe aging at baseline.

**DR. VAN VOORHEES:** How frequently did the daily sunscreen users really use their sunscreen and how can you be sure that they truly did? Were you able to control for factors such as smoking or other risks which we know will damage the skin? How about the exact ingredients of the sunscreen or its sun protection rating — did this matter?

**GREEN:** By the end of the trial 77 percent of daily sunscreen users were applying sunscreen at least three to four days a week compared with 33 percent of discretionary users. Every three months adherence to the sunscreen protocol was assessed by measured weights of returned sunscreen bottles (intervention group). We were able to control for factors such as smoking or other risk factors that damage the skin purely by the randomization, meaning that equal proportions of people in the treatment groups were exposed to these factors.

Whether our results would have differed with a higher SPF sunscreen (15+ was all that was available when the trial commenced) or one with greater absorption in the UVA spectrum is debatable, since the factor of overriding importance is the application of a liberal quantity of sunscreen and the SPF or precise shape of the sunscreen-absorption spectrum is much less important.

**DR. VAN VOORHEES:** I’m sure that you have read the recent paper in JAMA Dermatology by Steve Feldman’s group reporting that physicians are actually less dutiful about reminding patients to use sunscreens than we believe about ourselves. That paper suggests that dermatologists tell patients to use sunscreen only 1.6 percent of the time. Do you think that your study may help convince all of us to redouble our educational efforts in this regard?

**GREEN:** We’ve shown that regular sunscreen use by young and mid-aged adults under 55 brings cosmetic benefits, while decreasing their risk of skin cancer in the long-term, so my hope is that these results will enable dermatologists to tell patients about the cosmetic benefit of sunscreen and other sun protection. The flip side is that not being sun-safe will have a negative effect on their appearance as well as raising their chances of developing skin cancer. 

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As Bryan leans back in his office chair, his receptionist rushes in and tells him Jordan is calling and sounds frantic. Bryan begins the conversation.

Bryan: Hello, Jordan! It’s been a while since we spoke. How are you?

Jordan: Not well, Bryan. A patient of mine has ripped out the sutures I placed during a surgical procedure because he said the site itched so much he couldn’t stand it. He blames the itching on my having given him an ointment that I knew he was allergic to. My receptionist tells me he has an appointment to come in this afternoon and he is furious. What should I do?

Bryan: First of all, you need to check the facts. Do not assume anything. Did he really use the ointment you prescribed? Many medications have names that sound quite similar. Did the pharmacist fill the prescription correctly?

Jordan: I will certainly do that. But I’m afraid that I may actually have made a mistake. What else should I do?

Bryan: When he comes in, spend the necessary time with him even if you have to get behind schedule. If a patient was bleeding, you wouldn’t hurry out of the operating room to stay on schedule. Although I am aware that some of my legal colleagues advise scheduling the patient to return so that you have more time to spend with him, a patient who is livid may never return. If you don’t talk about his concerns when he is in your office, he may feel you are unconcerned or even callous. Your best (and possibly only) opportunity to discuss the situation with the patient in person is when he returns to your office this afternoon. Believe it or
not, many times patients go to attorneys not necessarily to pursue legal action but to understand what happened.

**Jordan:** When I speak with the patient what should I say or not say?

**Bryan:** Above all, listen to the patient. He will tell you exactly why he is angry. Always be honest. If it seems appropriate, reiterate the need for the procedure and any positive outcomes (e.g., the malignancy is gone) but do not go overboard and appear defensive. Clear up any misunderstandings or misconceptions.

**Jordan:** What should I do about the surgical wound?

**Bryan:** Always try to mitigate damages by addressing the patient’s medical needs. If he indeed reacted to the topical ointment perhaps he needs medication to relieve the itching. Maybe the wound needs to be re-sutured.

**Jordan:** How should I react if he tells me I am responsible for this situation?

**Bryan:** Although you may not want to deny responsibility, you should be careful not to admit liability. A statement such as “I am sorry I gave you the wrong ointment” is usually admissible in a legal proceeding.

**Jordan:** Does that mean that I cannot apologize?

**Bryan:** That depends. Thirty-six states have “apology laws” which prohibit expressions of regret, sympathy, or benevolence from being entered as evidence of wrongdoing. They do not, however, usually protect you from an admission of fault. Therefore, if your state has an apology law, you may be able to say “I am sorry that you had that much itching.” An apology is usually appreciated by patients and conveys the fact that you are a caring, sympathetic doctor. Remember, patients usually hesitate to sue physicians they like. Apologizing may also be the ethically correct thing to do and help both you and the patient obtain closure. Remember to document the apology in the patient’s medical record.

**Jordan:** Great! If it is appropriate I will apologize.

**Bryan:** If you do so, remember that your tone, expressions, and body language will convey as much to the patient as your spoken words. You want to come across as caring and concerned, not hurried or arrogant.

**Jordan:** Is there anything else I might want to do?

**Bryan:** Yes. If after checking the facts you find that you did not make a mistake, you may want to suggest that the patient get a second opinion from one of your colleagues. You may even want to offer to call that colleague to facilitate the patient getting an appointment. This would not only reflect your genuine concern for the patient but also would reaffirm the appropriateness of your treatment decisions.

**Jordan:** I will consider doing that. Do I need to report this to the Board of Medicine?

**Bryan:** Most state laws describe specific incidents that need to be reported, such as surgery on the wrong patient or wrong site. State laws may also specify that such incidents need to be reported only if they happen in a hospital or other inpatient facility. If a legal action is filed, however, many states require that the incident then be reported to the Board of Medicine.

**Jordan:** I understand.

**Bryan:** Remember that if you really made a mistake and prescribed the wrong medication you may need to report the incident to your malpractice insurance company. You have a duty to report adverse incidents and failure to do so may relieve the insurance company of its duty to defend you.

**Jordan:** Thanks, Bryan. I will do that.

**Bryan:** Jordan, also remember never to alter the medical records. Such an action would call your integrity into question should the patient pursue this matter. Finally, please call me after you see the patient so that we can discuss how it went.

### KEY POINTS

1. Always check out the facts. Never assume anything.
2. Make time to discuss the situation with the patient when he is in your office. It may be your only opportunity to do so.
3. Be honest, sincere, and compassionate.
4. Depending upon the law in your state, consider apologizing.
5. A statement of liability, unlike an apology, is frequently admissible in legal proceedings.
6. You have a duty to report adverse incidents to your insurance company. Depending upon circumstances and state law, you may have a duty to report incidents to your state Board of Medicine.

If you have any suggestions for topics to be discussed in this column, please e-mail them to me at loberc@gmail.com. See the February 2013 issue of Dermatology World for disclaimers.
EVERY OTHER MONTH, DERMATOLOGY WORLD covers technology issues in Technically Speaking. This month’s guest author, Warren R. Heymann, MD, relates his experience with implementing electronic health records as a late-career dermatologist. Dr. Heymann is professor of medicine and pediatrics and head of the division of dermatology at Cooper Medical School of Rowan University.

"Dr. Heymann, if you were 20 years younger you would have had that note finished by now."

"Mrs. Falcone, if I was 10 years older, I'd be OUTTA HERE!" (With all due respect to the late Phillies broadcaster Harry Kalas).

Since childhood, I have been told that the golden age of medicine has disappeared. When I was 10 years old (in 1965) I recall the grumblings of our general practitioner that socialized medicine would destroy American medicine. From the time I graduated medical school in 1979, the progression of DRGs, capitation, PPOs, HMOs, CLIA, HIPAA, RACs, and currently the ACA (Obamacare), has provided a relentless drumbeat of administrative dictates making me wonder if I would have the wherewithal to survive.

Of all the transitions, however, only the implementation of electronic health records was accompanied by foreboding dread. Why? I learned how to type in Mrs. McManus’ 7th grade class, graduated from a Royal typewriter to the Smith Corona electric to a word processor to Word Perfect to Word and from PC to Mac to iPad. I know I will never be as proficient as a toddler breastfed on electronics, but for someone my age, I am not a Luddite.

Regardless, the fear was real, yet the time had come to switch. There were obvious reasons to do so — get whatever monetary incentive Obamacare would allow and avoid the penalties of delayed implementation. Perhaps it may not make economic sense for an older physician in solo
practice considering retirement in the near future. As part of a group (as the senior member) there really was no choice. EHR is the future and there is no going back. What tipped the balance for me, however, was a simpler reason — I had to admit that my handwriting had gotten so awful that even I could not translate it.

Our program is iPad-based, and although not completely intuitive, reasonably easy to learn. I have now used it for approximately two months, and have become more facile with it. Admittedly, the first couple of days were harrowing, despite cutting our schedules in half and having an expert in the program guide us through the process (following 20 hours of lessons prior to going live). While I do not believe that I will ever see quite the same number of patients that I have in the past, I can attest that there are distinct advantages: 1) the electronic prescribing is a delight; 2) photodocumentation with the iPad is a pleasure; 3) finding patient data and writing notes on patients when on call away from the office is painless; 4) being confident about proper documentation for the level of service billed, thereby avoiding undercoding for more difficult cases; and 5) being able to read what transpired.

I am still working on what I perceive is the biggest disadvantage — the new paradigm of the doctor-patient-iPad, instead of the classical doctor-patient relationship. Fortunately, most patients are very accepting of this as they are experiencing this phenomenon with all their physicians. I have found the best way to handle this is to turn around and show them what I am doing and how the note looks — most are quite impressed!

Being patient was never my forte; I thought this might improve with age, but it has not. With paper charts, if you are running behind, you could take a few shortcuts on your notes using some acronyms or symbols — no longer. Should your pen run out of ink, you would just reach in your pocket for another pen — now when the “cloud” is taking its time to respond, and the iPad says “saving,” which seems to go on in perpetuity, all you can do is look to the heavens (isn’t that where the “cloud” is located?) and pray that the system does not crash. While it may only be for a moment or so, those minutes add up — 10 or 15 “absence seizures” a day not only equates to lost patient revenue, but, more importantly, puts you further behind schedule.

I understand that perception is reality; I recall spending hours in the medical school library, in the stacks with Index Medicus, striving to find the right article. Now, if it takes me more than three milliseconds to do my research on PubMed I have a fit. Having become accustomed to instant information gratification, any aberration in that process seems like an eternity.

Even if you become enamored and capable with your EHR, it does not mean that the front desk and nursing staff share your enthusiasm and ability. Even though everyone in our practice started together, it certainly did not mean that we all advanced at the same pace. Here is where my impatience has also gotten the better of me — this has led to periodic undue stress as so many issues regarding patient flow came to the fore. Constant vigilance and a willingness for all the staff (especially me) to be flexible to new approaches in handling patient reports, laboratory data, and electronic prescriptions were absolutely necessary to make the system work.

A final paradox — only rarely did I ever re-read my handwritten notes to make sure there were no glaring grammatical or spelling errors. Now when I find such errors in my notes, it really galls me. Maybe this has to do with my years of editing. Perhaps because of the clear legibility of EHR, I feel compelled to get it right. For someone with compulsive tendencies, this has the potential to drive you insane! As I am writing this essay during the Jewish High Holidays — a time of introspection — I am trying to convince myself that I need not be so particular when it comes to such errors. Alternatively, it is all too easy to have genuine substantive errors in the note if you click on the wrong template, or do not modify the correct template — one has to be alert!

So yes, fellow senior dermatologists, I am surviving. The EHR will get better and so will I, at least until the implementation of ICD-10!
As the largest country in the world by population, China faces the logistical issue of providing health care to over 1.3 billion citizens. A total of 18,000 dermatologists serve the needs of that population, mostly through hospital systems. Specialists are highly encouraged to publish research and engage with international colleagues. As the health system continues to modernize in reaction to the need for services, dermatologists have gradually become better organized and more involved in pushing the frontiers of the specialty.

AN EVOLVING CARE SYSTEM
Since the 1949 governmental initiative to improve overall health conditions in the population, the Chinese health system has undergone a number of sea changes. A 2008 series of articles in the *Lancet* divided the evolution of health care in modern China into five phases:

1949-1965
Following the establishment of the People’s Republic of China, the government took over the patchwork health care system and devised a centrally-managed three-tier care delivery system. New schools for medicine and nursing were established.

1966-1976
The Cultural Revolution closed universities and medical schools for a five-year period. The “barefoot doctor” program was introduced and trained tens of thousands of rural citizens in basic medicine to provide care to the underserved.

1977-1989
Rapid economic development led to further systemic reforms. Responsibility for health care management was decentralized to the provinces, which increased the disparities between urban and rural care. Financing for health services began to privatize. The barefoot doctors program...
was abolished in 1981 as the commune system ended.

1990–2002
The government attempted to control quickly rising costs, as well as address the health costs of rapid economic development, including obesity, workplace injuries, and health issues caused by pollution. Fledgling private providers and health care facilities began to operate and expand to meet the demands of the new, mostly urban middle class.

2003–present
Following the highly public fallout from the SARS epidemic, the health care system was fundamentally reformed, with more resources allocated to public health and a partial resumption of centrally-managed health care services. (The system had been portrayed in international media during the epidemic as poorly coordinated and inequitable.) A new cooperative medical system was created for the rural poor, with a similar program put in place for the poor and underserved in urban areas. Under the new health system, the annual cost of medical care under these programs is 50 yuan (about $8) per person. Of that, 40 yuan is paid by the central and provincial governments, and 10 yuan is charged to individual citizens. (China’s annual income in 2012 was 13,000 yuan, or about $2,100, with lower incomes seen in rural areas.)

The many and ambitious changes in approach over the years have required the allocation of considerable resources. Much of the funding for these public health initiatives in both China and its special administrative region of Hong Kong, according to private practice dermatologist Henry Lee Chan, MD, who practices in Hong Kong, comes from reallocated taxes on individuals.

“While Hong Kong has a very low tax system — 15 percent personal tax as a flat rate — we have a very good health care system with the public services providing care to the underprivileged,” he said. “The system serves as a safety net and is important to the community.”

Former Academy president Stephen P. Stone, MD, who traveled to China on three separate multi-city speaking tours, said that the recent efforts at modernization have resulted in facilities and academics that compare very favorably with Western medicine.

“The first time I traveled to China, I was initially surprised at just how up to date the major hospitals were,” Dr. Stone said. “It was quite clear that the Chinese are keeping up with Western medicine today, though there is still some investigation of and definitely a market for traditional Chinese medicine.”

ROOTS OF THE SPECIALTY, CURRENT ORGANIZATIONS
China has one of the oldest traditions of medicine in the world, and likewise, dermatologic conditions have been studied and treated for centuries by both traditional and contemporary medical practitioners. According to a 1982 piece in the *Archives of Dermatological Research*, excavated remains of the Shang Dynasty included words such as “chieh” (scabies) and “pi” (head lesion) carved onto turtle bones. During the Chow dynasty (1066-771 BCE) physicians who dealt with cutaneous disease were classified as surgeons under the Chow Rituals, which distinguished four classes of doctors. In 610 CE, Tsao Yuan-Fang published a work titled *Etiology and Pathogenesis of Diseases*, which included descriptions of over 60 skin diseases.

Medical dermatology was introduced (as dermatovenereology) to China via American and European missionary physicians in the middle of the 19th century. A number of hospitals were established to bring Western-style medicine to the country. A number of hospitals were established to bring Western-style medicine to the country.

The following century, in 1931, dermatologists Chester N. Frasier, MD, and Ch’uan-K’uei Hu, MD, reported hypovitaminosis A for the first time at Peking Union Hospital (*Arch Intern Med* 48:507–14). Soon after, in 1937, the Chinese Society of Dermatology was founded as a sub-section of the Chinese Medical Society.

Today dermatology residency in China
is a three-year process, undertaken following three years of general medical training. Following completion of residency, students are able to take their medical boards, administered by the Ministry of Health. “The dermatology board exam is given as a step 1 and step 2 by each university, as they don’t have any equivalent to the American Board of Dermatology, for example,” said American Academy of Dermatology President Dirk M. Elston, MD, who recently returned from a trip to China. “Laser and dermatopathology certificates are delegated to provincial governments, much like state medical licenses in the U.S.” After licensure, Dr. Elston said, promotion and career advancement is largely based on published research in Western journals.

Indeed, as a result of recent health system reforms, grants are now more widely available for dermatologic research. More than 300 papers from Chinese dermatologists have appeared on the Science Citation Index over the previous five years (J Invest Dermatol 129: 1049-1056).

“Many of the dermatologists in China do research fellowships in the U.S. before going to China and entering practice. Being published in a Western journal in English is certainly an aid to one’s academic career,” Dr. Stone said.

Interest in dermatology among Chinese physicians continues to advance. In 2007, the Chinese Society of Dermatology voted to increase the frequency of its scientific meeting from bi-annual to annual. The society also partners with the Japanese Dermatological Association to host joint meetings. In 1998, 2004, and 2007, the country hosted international meetings for the Asian Congress of Dermatology, the International Congress of Dermatology, and the International Society of Cosmetic Dermatology. In 2013, the 9th Asian Dermatological Congress was held in Hong Kong.

In addition to the Chinese Society of Dermatology, the Chinese Dermatologic Association began in 2008 as a small trade association and now has a small scientific meeting each year.

PRACTICING DERMATOLOGY
In contrast to the U.S., almost all dermatology practiced in China is hospital-based. “The responses that I heard during my visit to China all alluded to the fact that the population trusts care in a hospital setting and doesn’t view private practices as equivalent,” Dr. Elston said. “The major drawback to the system is that patients come in without appointments and push the demand so high that the dermatologists have less time with the patient than they would like. It’s about twice the number of patients that a dermatologist in the U.S. would consider a comfortable volume.”

To combat the effects of the overcrowding that can occur, Dr. Chan said, his practice sends all its staff members to a hotel service training course, as do some other practices. The cross-training, he said, helps them improve their communication skills and ability to relate to patients.

On speaking with the dermatologists in China over the course of his visits, Dr. Stone said that, like Dr. Elston, he was struck at the lower proportion of solo practitioners in the country compared to the U.S.

“The impression that I had in speaking with dermatologists in China was that the specialty is more of an academic specialty in the way of France and Great Britain, where many of the researchers are professors, are hospital-based, and are teaching,” he said.

The major conditions treated by dermatologists in China are eczema, psoriasis, and connective tissue disease, according to Dr. Elston. In addition, he said, a number of therapies not approved in the U.S. are offered at clinics geared toward traditional Chinese medicine.

Patients in China and Hong Kong, according to Dr. Chan, display different sensitivities to certain conditions. “Here, patients are more prone to develop complications after laser procedures,” he said. “Especially post-inflammatory hyperpigmentation.” In addition, Dr. Chan said he sees pigmentary conditions with a greater frequency than Western dermatologists, including nevus of Ota, lentigines, and Hori’s nevus. And he uses different treatment modalities than his American colleagues.

“Quite recently, I wanted to refer a patient with extensive alopecia areata, which was well-controlled with diphenyl-cyclopropenone,” Dr. Chan said. “I reached out to colleagues in Boston and found that nobody there performed such treatments.” During his visits, Dr. Stone said, it was clear the dermatologists in China were able to utilize many drug therapies not yet approved in the U.S.

“Many of the medications that had not yet been approved in the U.S. but had been approved in Europe were available in very similar forms. International pharmaceutical companies are certainly present. During one of the sessions, the organizers played an animated cartoon commercial for a topical antibiotic between the talks,” Dr. Stone said. “This was in the urban areas. Some of the more rural areas we remote-broadcasted to did not have access to imiquimod and some of those types of newer drugs, but they were certainly available in the cities.” dw
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Data illuminates path to continued viability

Dermatology practices look to benchmarking to protect finances as health system evolves
As the payment landscape changes, dermatologists and practice managers continue to look for ways to protect practice revenue while safeguarding quality. To do so, many have begun to delve deeper into the data generated by the day-to-day practice of medicine — on satisfaction, quality, and cost. By turning to one of a growing number of consultants or simply knowing what to look for in their practice performance data, dermatologists can figure out their practices’ strengths and weaknesses, make the case for their value to payers — and safeguard their future.

RESPONDING TO PRESSURES
Once the domain of hospital systems and larger groups, the use of advanced practice data is becoming increasingly popular among small practices and solo dermatologists. The driving reason for this data renaissance is the increased use practice management software systems (PMSS), coupled with steady growth in the adoption of electronic health records (EHR) in dermatology practices, which make collecting, aggregating, and interpreting the data more efficient than ever. The government-driven EHR mandate, coupled with anxiety over both recent changes and the changes forthcoming under the Affordable Care Act (ACA), has made many practices and physicians more interested in using benchmarking tools, according to Michael Sanderson, president of medical analytics company RemitDATA. >>
“Why are doctors listening now who five years ago could care less? There are a few factors. One is all the new rules under the ACA and the loss of productivity that implementing many of these changes has caused (for example, installing and meaningfully using an EHR system). Another is the pending fee-for-quality payment methodologies,” Sanderson said. “Another big one is compliance — everyone’s looking at their data. They have RAC contractors and payers trying to catch them making a mistake. It took that for many physicians to realize that they’d been in the dark and it was time to do something about it.”

Scottsdale, Ariz., dermatologist W. Patrick Davey, MD, MBA, said that the mounting pressure of payment system change emphasizes the need to be not only aware but proactive on the bottom line of one’s practice.

“Now we’re all predicting revenues going down, so we’re going to have to find ways to reduce our costs. Using benchmarking gives you a report card as to where you stand and where you can enhance your cost structure,” Dr. Davey said. “As physicians, we’re always taught to do everything for everybody. But if you don’t have a margin, you don’t have a mission. You’re going to have to shut down. We’re going to have to start thinking more and more about how to be more cost effective in doing things, and part of that is identifying where you stand currently.”

Another factor in increased financial scrutiny among dermatologists, according to Kevin Smith, director of the Allergan Practice Consulting Group, is that the recession caused a dip in practice revenues that has only just begun to subside. During this time, he said, practices began to address their shortcomings and diversify their sources of income.

Revenues, Smith said, are just now getting back to 2007 levels for dermatologists. “At one point during the recession 65 percent of practice revenue among our clients was coming directly from the physician provider. By 2011, that was down to 57 percent, because practices were diversifying. They added retail products, they sought to bring in self-payers and cosmetic patients, and they brought in PAs and NPs.”

**FINDING MEANINGFUL COMPARISONS, ADDRESSING WEAKNESSES**

During his time as a member of a 10-physician practice in Kentucky, Dr. Davey frequently used to compare notes with a dermatologist colleague of his from Kansas City on practice and payer performance. At the time, it was an attempt to get a sense of his practice’s place in the larger world of dermatology. Today, he said, even small practitioners need to do so much more to get an accurate sense of where they stand, including pulling information from their EHRs and/or getting assistance from companies that provide data and consulting services.

“What everyone needs to do is establish a financial dashboard of metrics they should be looking at to give them insight into where they can improve revenues and increase efficiency,” Dr. Davey said. “You need to invest in the resources to compare yourself to similar practices. When I was in Kentucky, the physicians used to benchmark our coding and performance next to each other’s. Now that I’m in solo practice, I’ve been taking advantage of outside resources to compare.”

In the present health system, Sanderson said, even the specialty surveys put out by management groups fail to provide the necessary level of data for practitioners to act upon them meaningfully.

“A good denial rate nationally is 12 percent. But that’s worthless information. Take a doctor in Chicago and a doctor in Dallas, for example. The doctors are in completely different locations, so the national number is less relevant than the denial rate for their market and for the basket of codes that they do,” Sanderson said. “Valuable analytics would allow a physician to create a custom benchmark relative to their payer mix in their markets and the procedure mix in their practice.”

Benchmarking can also help dermatologists assess the risk that their practice patterns will trigger an audit or otherwise make them look like an outlier to payers. (See sidebar for the impact this can have in terms of being a participating provider in an insurer’s network.)

**COMPARING PAYERS**

Beyond benchmarking their own practices, dermatologists may also want to review how their payers stack up. One tool for doing so, the 2013 National Health Insurer Report Card, may be a useful reference for dermatology practices to assess payers on a number of performance metrics, including timeliness, transparency, and accuracy of claims processing. It is available online at www.ama-assn.org/resources/doc/psa/2013-nhirc-comparison.pdf. A second tool, the 2013 PayerView Report, addresses payer industry trends and ranks based on their performance metrics. It is available online at www.athenahealth.com/our-services/PayerView/medical-claims-billing.php?intcmp=OUR-SERVICES/PAYERVIEW.PHP.
“A single doctor in a small practice can access these tools and drill down to see where they rank among dermatologists percentile-wise in their market. That score is marked across payer efficiency, staff efficiency, and provider efficiency,” Sanderson said. “Am I as a dermatologist doing more level 4 E/M codes and thus exposing myself to higher audit risk? We can tell them via simple remittance data.”

One of the more complex tools to evaluate financial performance is the figure for procedure value per hour — that is, how much value does a certain procedure provide to the practice relative to the time and resources it costs the office? Different practices and practice management organizations use different values to arrive at their conclusions, as it’s a complex system to analyze, according to Smith.

“It can be tough to calculate the procedure value per hour. You could say that the government has done it for you with the resource-based relative value scale. We look at it as the time for a consultation, whether a procedure is involved, the cost involved with the procedures, and the follow-up visits and global periods during follow-up care,” Smith said. “This is where benchmarking is important. Providing good outcomes is the most important aspect of providing care, but if you look at follow-up within a global period, what do your peers do? Can you use a nurse to remove sutures or use your ancillary personnel to the scope of their licensure to free up the physician for seeing more patients and generating revenue?” Letting non-physician clinicians and other ancillary personnel work to the full extent of their licensure, he said, can improve a practice’s financial performance.

It’s important to note, Sanderson said, that a growing number of analytics and consulting companies provide data to physicians via either EHR or PMSS on remittance data from payers. There’s no need to switch one’s practice to a proprietary system or add additional processes (besides actually looking at the data) to make meaningful changes. The data, he

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**BENCHMARKING DERMATOLOGY CODES**

According to medical analytics company RemitDATA, 99213, an established patient visit code, is the most-paid and most-denied code in dermatology. Other findings from the company’s data, based on information from more than 100,000 physicians and providers, appears below.

**Top 5 paid codes**
- 99213: established patient office visit
- 17311: first stage of Mohs surgery, head, neck, or extremities
- 17000: destruction, premalignant lesion
- 17110: destruction, benign lesion
- 11100: biopsy

**Top 5 denied codes (by count)**
- 99213: established patient office visit
- 17000: destruction, premalignant lesion
- 17110: destruction, benign lesion
- 99212: established patient office visit
- 17110: destruction, benign lesion

**Top 5 denial reason codes (by dollars)**
- 45: Charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement.
- 223: Missing documentation of benefit to the patient during initial treatment period.
- 23: The impact of prior payer[s] adjudication including payments and/or adjustments.
- No code present
- 144: Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
said, is already being generated. It just takes an active interest by the physician or practice manager to begin utilizing it.

“90 percent of our client base is getting the electronic version of the remittance they’re already getting from payers,” he said.

**ANALYTICS AND ACOs**

As the health system looks to trim the cost of treatment per patient, the accountable care organization (ACO) model places a similar onus on providers — from primary care to specialists of all stripes — to participate in the same kind of benchmarking, both financial and outcomes-based. Dermatologists even slightly interested in exploring a future as a member of an ACO should already be benchmarking and analyzing practice patterns and performance data, Sanderson said.

“For a physician to consider an ACO, they have to first figure out where they would rank in their given market. If I’m a single dermatologist in the Dallas-Fort Worth area, for example, and Baylor or Aetna is forming an ACO, before I even consider sitting down at the table, I’d better understand if I am a lesser-producing, less-efficient, or higher-compliance-risk doctor compared to my peers,” Sanderson said. “You need to know your practice and how you compare, because everyone else around that table will have a pretty good idea of what you’re doing. If you walk in blind, you’re toast. On both sides of that table, transparency is key. You go to these meetings, you’ll see nothing but analytics.”

ACOs, Dr. Davey said, will include standardized financial and performance benchmarking as a matter of course for continued participation. But just getting

**DATA CAN HELP DERMATOLOGISTS MAKE THE CUT IN NARROWER NETWORKS**

Having data about one’s practice at the ready is a good strategy for finding ways to enhance revenues. In a changing health care environment, according to William Brady, senior manager of practice management resources at the American Academy of Dermatology, it may also give dermatologists an advantage in negotiations with payers that are increasingly data-driven.

“Payers already have a picture of practices based on their own data,” Brady said. “Every time a medical practice submits a claim and it is paid, it creates a data point that informs the practice’s profile in that payer’s database.” A paradigm shift toward using that data to determine which providers to include in networks began when the 2010 Affordable Care Act required Medicare Advantage plans to follow a ranking system that gave plans that met certain value- and quality-based criteria a higher star rating than plans that did not. [Plans that succeeded in meeting the criteria, in addition to a higher star rating, received bonus payments.] As the same insurers roll out plans to offer in the ACA’s health care exchanges, where they will compete based on prices that are transparent to potential customers, they have even more incentive to try to control their costs, Brady said.

The key for dermatology practices, Brady argued, is to turn the threat this poses into an opportunity.

“You can challenge decisions to exclude you from a narrower network of providers,” he said. “If you have and understand your practice data, you can use it to educate a payer — regarding the details of both your specialty in general and your practice in particular. You can use your data to help them understand the reasons underlying your data in their system — demographics, disease severity.”

If a payer that has typically included your practice in its panel excludes it from a narrower network for a Medicare Advantage or exchange-sold plan, he said, “Find out why you’re excluded. You can refute the rationale they offer by providing a more complete and fairer picture of your practice using the data that only you have — data for your entire practice, and detailed information about your patients from that specific payer.” While the data payers have collected is robust enough at this point to offer what may appear to be a complete picture, it still
there involves proving that one is already the type of physician who will benefit the larger affiliation.

“The majority of medical dermatology will be in that ACO model,” he predicted. “So you’re going to have to prove to the ACO that you can do things in a more cost-efficient, effective manner. That you get the correct diagnosis and treatments to begin with is important.”

In addition, one of the more frequent questions from specialists is how they’ll be compensated under an ACO as opposed to the current fee-for-service system. With an accurate financial dashboard and historical data, Sanderson said, one can more or less ascertain the benefit of a given ACO contract quickly.

“The other side of benchmarking, apart from seeing your performance, is predictive modeling. An ACO will come to you and say ‘we’ll pay you X amount to accept risk.’ This allows you to take historical data on a real-time basis and project it onto the new compensation model and current utilization model,” Sanderson said. “Predictive modeling will tell you what you’ll make. Really, a tiger doesn’t change its stripes too much. The past is a good indicator. Benchmarking tells you directly that, based on historical patterns, here’s how this new compensation plan would impact you.”

While not every dermatologist may plan to join an ACO, Dr. Davey said that as the health system evolves, successful dermatologists will need to keep these figures in mind to assure the continued health of their practices.

“Going forward, not just for the financial health of your practice, but to be sure you’re providing the quality of care you want, you need to benchmark,” he said.

may not reflect the kind of risk-adjustment and consideration of practice demographics that are necessary to really understand the kind of value a practice provides to a payer. Practices that can make that case using their data and demonstrate the value proposition their practice offers will have success in the new environment.

In addition to internal data, some knowledge of the local market in general will prove helpful in dealing with payers, according to Richard Martin, JD, the Academy’s assistant director for regulatory policy.

“Networks for exchange plans are likely to have significantly smaller networks than Medicare Advantage or non-exchange plans,” Martin said. “Accordingly, an emerging issue will be adequacy of networks for patient access.” Successfully fighting to ensure that a network offers adequate options for patients, he said, will be driven by data outside the individual practice regarding the local market, the number of physicians in a payer’s network, and their respective specialties/subspecialties. Dermatologists who understand where their referrals come from and what dermatologic care is being provided to patients by primary care providers will have a leg up in these conversations, he said.

The network-narrowing trend is likely to continue, Brady said, and it is affecting physicians across the board. “This really forces physicians to look at how their cost and quality compare with others, and to consider whether there are ways to optimize their current practice arrangement to reflect this paradigm shift, or if they need to align themselves with organizations that have worked out best practices for achieving efficiency while maintaining quality of care,” he said.

In the meantime, he noted, the Academy continues to communicate with payers who narrow their networks in ways that could be harmful to patients by limiting their access to dermatologists. The Academy has a position statement on opposing financial-based credentialing that addresses many of the issues involved and may help dermatologists assess their own situations; search for credentialing at www.aad.org/Forms/Policies/ps.aspx.

– RICHARD NELSON
In each medical specialty and each generation, there are a handful of individuals whose contributions change the field. As the American Academy of Dermatology concludes its 75th anniversary celebration this month (learn more at www.aad.org/75th), Dermatology World chose five giants in the field’s past who helped chart the course of its future: Drs. Louis A. Duhring, Donald M. Pillsbury, Walter F. Lever, Frederic E. Mohs, and A. Bernard Ackerman.
LOUIS A. DUHRING (1845-1913)

Louis A. Duhring, MD, may be known as “Philadelphia’s first skin specialist,” but his legacy extends far beyond Pennsylvania.

After receiving his medical degree from the University of Pennsylvania in 1867, Dr. Duhring interned at Philadelphia (Blockley) Hospital. There, he became interested in skin diseases and went abroad to study dermatology. Dr. Duhring returned to Philadelphia and in 1871 opened the Philadelphia Dispensary for Skin Diseases, a move that raised dermatology’s profile among the other specialties. The same year, he was appointed a lecturer on skin diseases at the university, launching a 40-year career there. >>
In 1874, the university opened its own hospital, naming Dr. Duhring the first chief of dermatology. He also was appointed visiting dermatologist to the newly established dermatology department at Blockley Hospital. Dr. Duhring was made full professor at the university in 1890, making him one of the first professors of skin disease in America.

“Dr. Duhring is an important historical figure at Penn,” noted George Cotsarelis, MD, professor and chair of the department of dermatology at the University of Pennsylvania. He created the department of dermatology, which is the oldest in the country, he said.

Dr. Duhring is credited with authoring the first American textbook on skin diseases. He self-published the Atlas of Skin Diseases, which remained the definitive work on the topic for the next 50 years. His next book, A Practical Treatise on Diseases of the Skin, published in 1877, was translated into several languages, establishing him as a top American authority of dermatology. He published Cutaneous Medicine, a two-part encyclopedia; the third part was destroyed in a fire so the work was never completed.

Early in his career, Dr. Duhring described an uncommon inflammatory disease that was hotly debated at the time. That disease is dermatitis herpetiformis, which is now commonly referred to as Duhring’s disease.

Dr. Cotsarelis has had an opportunity to look at some of the textbooks that Dr. Duhring wrote as they are housed in the university’s archives. Dr. Cotsarelis was shocked at how similar the information in current textbooks. With regard to alopecia, a personal interest of Dr. Cotsarelis, not only were the descriptions accurate, the explanations of what causes it haven’t changed significantly either, he noted.

Dr. Duhring was also a founding member of the American Dermatological Association and twice served as its president. He was made an honorary member of dermatologic societies in five European countries.

Dr. Duhring died in 1913. A wise investor who started from a substantial inheritance, “he accumulated a significant fortune,” according to Pantheon of Dermatology, a book that chronicles the lives of more than 200 historic dermatologists. But he had no children of his own to leave it to (though, Pantheon notes, he was “generous with his nephews, nieces, and cousins”). Upon his death, he left more than $1 million to various Philadelphia organizations, with much of it going to the Penn dermatology department, helping to establish its world-renowned reputation. A wing of the university’s Furness Library (now the Fisher Fine Arts Library) was named in his honor, as is a laboratory. Portraits of Dr. Duhring hang on walls in many campus buildings.

“Historically, Penn has had a really great program and reputation and that, in part, goes back to Dr. Duhring,” Dr. Cotsarelis said.
given for his military service, he was bestowed the highest awards in his field. Dr. Pillsbury was an honorary member of dermatologic societies around the world. He also wrote five textbooks and published more than 100 scientific articles.

Since 1984, the University of Pennsylvania has hosted the Annual Pillsbury Dinner and Lecture. “His trainees established the lectureship in his honor,” explained Dr. Cotsarelis. “It’s an indication of how well loved he was.” While Dr. Cotsarelis didn’t know Dr. Pillsbury personally, he worked with Dr. Kligman, who did, and still remembers hearing stories about him. “Albert Kligman held Pillsbury in the highest regard. The word he always used was ‘angelic.’” And Dr. Kligman saw Dr. Pillsbury’s other talents firsthand as well, Dr. Cotsarelis said. “One day, he was amazed to see Pillsbury sit down and play the piano. There was a musical side to him that not many people were aware of.”

WALTER F. LEVER (1909-1992)
Walter F. Lever, MD, immigrated to the United States in 1936 from Germany where he received his training as a dermatologist. After finishing his residency at Harvard Medical School and Massachusetts General Hospital in Boston, he stayed on to do research in internal medicine. His focus was two-fold: bullous disease and dermatopathology. After receiving a grant from the NIH, Dr. Lever started his own research lab. Next, he was appointed assistant professor of dermatology at Harvard. Eight years later, Dr. Lever was named professor and chair of dermatology at Tufts University Medical School in Boston. “The department grew remarkably under his leadership, in part, because he was able to obtain NIH support for his research and training,” noted Dr. Moschella, who met Dr. Lever in the 1950s. He was also chief of dermatology at the Tufts service at Boston City Hospital and the New England Medical Center and remained a dermatologic consultant at Massachusetts General.

After World War II, Dr. Lever began giving courses in dermatopathology designed for physicians who were returning to practice after serving in the armed forces. Because there was no textbook to use, Dr. Lever wrote one. Now in its tenth edition, Histopathology of the Skin was the first dermatopathology textbook written in English, Dr. Moschella said. Dr. Lever was involved in writing eight of the 10 editions, which have been translated into several languages. Dr. Lever also authored two other textbooks, one of which he wrote with his wife Gundula Schaumburg-Lever, MD, and nearly 180 scientific articles. Among the latter is the first paper published in the JAAD in 1979.

Dr. Moschella routinely attended Dr. Lever’s pathology lectures at Massachusetts General. “Walter was a very forceful teacher and a good clinician,” he said. Dr. Lever was instrumental in teaching dermatopathology to generations of dermatopathologists, pathologists, and dermatologists.

He also was known as a worldwide authority on blister diseases, Dr. Moschella said. His research on bullous diseases led him to distinguish between pemphigus vulgaris, bullous pemphigoid, and dermatitis herpetiformis. Dr. Lever separated the blister diseases and cleared up a lot of confusion about them, Dr. Moschella said. Dr. Lever promoted the treatment of pemphigus vulgaris and bullous pemphigoid with an initial high dose of corticosteroids.

Dr. Lever was a founding member and past president of the American Society of Dermatopathology. He held an honorary membership in 16 dermatologic societies throughout the world. “Walter had a passion for what he did,” Dr. Moschella said. “He had a twinkle in his eye and a lot of energy. He was a little guy; I don’t know how he had so much energy. He never walked, he ran. When he talked, you couldn’t shut him up.” In addition to his energy, Pantheon notes Dr. Lever’s many hobbies, among them mountain climbing, skiing, travel, classical music, and opera.

Although Dr. Lever retired from the university in 1976, he continued to work in private practice and at his dermatopathology lab with his wife. In 1983, they returned to Dr. Lever’s native Germany, where Gundula took over the dermatopathology department at Tübingen.

FREDERIC E. MOHS (1910-2002)
Frederick E. Mohs, a general surgeon, is responsible for transforming dermatology into a surgical as well as medical specialty.

As a medical student and then cancer research fellow at the University of Wisconsin-Madison, Dr. Mohs pioneered the concept of microscopic control of skin cancer. He developed a zinc chloride paste that when applied to tumors as a topical fixative penetrated the tissue without causing systemic toxicity. Next, he used surgical excision to remove the tumor and a microscope to examine the tumor’s margins. These steps were repeated until the entire tumor was removed and the margins cleared. The wound was allowed to heal by secondary intention.

This fixed tissue technique, which became known as chemosurgery, was used for more than a decade. Although initially it was not widely accepted, its ability to allow for maximum tissue sparing, high cure rates, and excellent cosmesis won over the skeptics. Dr. Mohs received a patent for his fixative paste and sold it to the Wisconsin Alumni Research Foundation for one dollar. In 1967, he founded the American College of Chemosurgery, which is now known as the American College of Mohs Surgery.

The critics were silenced when this fixed tissue technique evolved into a fresh tissue technique. In 1969, Dr. Mohs reported a five-year 100 percent cure rate for 66 basal cell and squamous cell carcinomas of the eyelid removed using this technique.

Despite having revolutionized dermatologic surgery, Dr. Mohs was a modest, very unassuming individual, Dr. Goltz noted. Physicians from across the country,
including Dr. Goltz, referred the most difficult skin cancer patients to Dr. Mohs. “He operated in a little cubicle on a lawn chair. He charged five dollars a layer,” Dr. Goltz said.

When treating those patients, Dr. Mohs had a most gentle manner, recalled Stephen Snow, MD, a dermatologist in the Mohs surgery unit at Kaiser Permanente, who had a year-long fellowship with Dr. Mohs starting in 1981. Having heard about Mohs surgery, Dr. Snow contacted Dr. Mohs who promptly told him to “come on over and learn the technique,” Dr. Snow said. “I had no letters of recommendation. I had no contract. It was just his word that I had a job. That’s how he handled his fellowships. He was very unassuming.”

In 1982, Dr. Snow joined the faculty at the University of Wisconsin-Madison in the surgery department where he worked with Dr. Mohs until the latter retired in 1986. Dr. Mohs continued to come into UW Health Dermatologic/Mohs Surgery Clinic until the early 1990s.

He had a very gentle manner when it came to managing patients, Dr. Snow said. “He treated them like human beings, not just patients.” And his clinic was his baby. “It was important to him that we continue the clinic the way he set it up. He never told us that. You just knew it. He was very paternal.” In addition to his stewardship of his clinic, Dr. Mohs helped shepherd into being the First Unitarian Society Meetinghouse in Madison, working with Frank Lloyd Wright. The building is on the National Register of Historic Places and has been designated a National Historic Landmark.

In addition to making surgery a component of dermatology, which was previously considered a medical specialty, Dr. Mohs helped dermatologists claim skin cancer as their area of expertise, said David M. Pariser, professor in the department of dermatology at Eastern Virginia Medical School in Norfolk. Dr. Mohs trained a generation of fellows from across the country and around the world, said Dr. Pariser, who is also a member of the AAD’s History Committee. Today, all dermatology residency training programs in the United States must provide exposure to the Mohs technique; many second-and third-year residents receive hands-on experience.

“Without Dr. Mohs, dermatologists would still be doing only biopsies,” Dr. Snow concluded.

A. Bernard Ackerman (1936-2008)
A. Bernard Ackerman, MD, was to dermatopathology what Dr. Mohs was to dermatologic surgery, Dr. Pariser noted. “He was an icon of dermatopathology who helped define the field.”

A graduate of Princeton University majoring in religion and literature and of Columbia University’s College of Physicians and Surgeons, Dr. Ackerman did dermatology residencies at Columbia Presbyterian Medical Center, Hospital of the University of Pennsylvania, and Harvard-Massachusetts General Hospital. He capped those off with a dermatopathology fellowship at Harvard. Dr. Ackerman served as director of dermatopathology at New York University for 20 years.

During that time, he founded the International Society of Dermatopathology. In 1999, Dr. Ackerman founded the Ackerman Academy of Dermatopathology in New York City, in conjunction with AmeriPath, Inc. He served for five years as the director of the center devoted to the diagnosis, teaching, and advancing knowledge of skin diseases.

His overarching contribution to the field is the algorithms that Dr. Ackerman developed for interpreting and classifying inflammatory diseases, Dr. Moschella said. These were published in the book entitled Histological Diagnosis of Inflammatory Skin Diseases in 1978. Dr. Ackerman’s emphasis on pattern analysis had a profound influence not only in dermatology, but in pathology, as well. He went on to write approximately 60 books in which he covered every aspect of dermatopathology. Among his groundbreaking publications were Differential Diagnosis in Dermatopathology, The Lives of Lesions, Pitfalls in Histopathologic Diagnosis of Malignant Melanoma, and Clues to Diagnosis. “Bernie applied what he called Sherlockian dermatopathology in which he looked for clues to arrive at a diagnosis,” Dr. Moschella said. He also contributed criteria for recognition of mycosis fungoides, Kaposi’s sarcoma, and melanoma in situ.

Dr. Ackerman published more than 700 scientific papers and even started two journals: The American Journal of Dermatopathology and Dermatopathology: Practical and Conceptual. He was also involved in creating the website www.derm101.com.

Dr. Ackerman may be best known for his 27-headed microscope. Students from around the world came to sit around it as he reviewed hundreds of cases, noted Dr. Moschella, who never missed an opportunity to visit with Dr. Ackerman when in New York. “His mastery of art and science in lecturing made him a legend,” he said. “Bernie mesmerized the audience with his interludes of musicians and artists.” Dr. Ackerman is credited with training more than 400 dermatopathologists.

He was an intellectual and combatant at times, Dr. Moschella said. “He didn’t tolerate or defend ignorance and critiqued everybody, including himself.” But he also was generous and created numerous educational grants for medical students. Among them is the A. Bernard Ackerman Endowment for the Culture of Medicine at Harvard Medical School, designed to encourage collaboration among the arts and sciences, medical school, and other departments. Additionally, he donated a dermatopathology reading room at Massachusetts General Hospital. dw
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Identifies five tests and treatments dermatologists and their patients should question
You’ve heard the old adage “too much of a good thing,” but probably not in the context of health care...until now.

The American Academy of Dermatology (AAD) recently identified five commonly performed medical tests and treatments that are not only potentially unnecessary, but could be harmful, as part of the Choosing Wisely® campaign. (See sidebar for list.)

Launched by the American Board of Internal Medicine Foundation in 2012, the campaign’s goal is to encourage conversations between physicians and patients about what care is really necessary for specific conditions. To date, more than 50 medical specialty societies and nearly 20 consumer groups are involved in the campaign. The societies identify the “Five Things Physicians and Patients Should Question” while Consumer Reports develops accompanying patient-friendly materials and works with consumer groups to disseminate them widely. The AAD is joining in the third wave of lists released between now and March 2014. The additional 30-plus lists build on a library of more than 130 tests and procedures already identified.

“The Choosing Wisely campaign is a unique opportunity for our specialty, from within, to identify areas where we think certain tests, treatments, or procedures might sometimes be used at the wrong times or in the wrong circumstances,” noted Jack Resneck Jr., MD, the AAD’s Choosing Wisely Workgroup’s advisor and associate professor and vice chair of dermatology at the University of California San Francisco School of Medicine. “As dermatologists, we have special expertise to make these assessments and help patients and their referring physicians to better weigh the risks and benefits of specific interventions.” >>
WHY THIS, WHY NOW?

It is estimated that as much as 30 percent of the nation's health care spending is wasted on duplicative or unnecessary services, according to the Institute of Medicine and others. Moreover, these inefficiencies could lead to harm. By one estimate, cited when the IOM released the report “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America” earlier this year, approximately 75,000 deaths could have been averted in one year if care had been delivered at an optimal level.

“The Choosing Wisely campaign comes at a time when it is becoming increasingly recognized that we need to change the way we practice medicine,” said Kathryn Schwarzenberger, MD, a workgroup member and the Amonette-Rosenberg Professor and Chair of the University of Tennessee's dermatology department. There is an increasing focus on making sure that physicians are providing the right treatment to the right patient.

Alice J. Watson, MD, MPH, a workgroup member and resident of the Harvard Combined Dermatology Program in Boston, pointed out that dermatology as a specialty is facing a lot of external pressure and uncertainty around payment. Consequently, it's important that dermatologists demonstrate that they are committed to being good stewards of the health care resources they manage, said Mary-Margaret Chren, MD, a workgroup member and professor at University of California San Francisco School of Medicine. “Taking responsibility for making these recommendations from within our specialty is far more desirable than having insurers and government payers fill the void and make them for us,” Dr. Resneck added.

A LIST IS CREATED

The six-member workgroup was convened this past January. Members included dermatologists who also serve on the Academy's Board of Directors; Council on Science and Research; Council on Government Affairs, Health Policy, and Practice; Research Agenda Committee; Clinical Guidelines Committee; Access to Dermatology Care Committee; Patient Safety and Quality Committee; Resource-Based Relative Value Scale Committee; and Workgroup on Innovative Payment and Delivery.

To start, the workgroup members reviewed the AAD's clinical practice guidelines, quality measures, and appropriate use criteria for Mohs micrographic surgery, all of which are backed by strong evidence, noted Roseanne Fischoff, MPP, the AAD's director of science, quality, and practice. According to the Choosing Wisely criteria, patients and physicians should choose treatments that are supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary.

FIVE QUESTIONABLE TESTS/PROCEDURES/TREATMENTS

The AAD identified the following “Five Things Physicians and Patients Should Question” as part of the Choosing Wisely campaign.

Don’t prescribe oral antifungal therapy for suspected nail fungus without confirmation of fungal infection.

There are a lot of anti-fungals prescribed for what looks like nail fungus but is really a nail dystrophy or congenital problem, said Brett Coldiron, MD, chair of the AAD’s Choosing Wisely Workgroup. Only half of all cases of suspected nail fungus involve a fungal infection. Therefore, prescribing antifungals without getting a positive culture won’t treat the problem. Without an accurate diagnosis, patients are subjected to taking expensive drugs, some of which are associated with liver toxicity, he added.

Don’t perform sentinel lymph node biopsy (SLNB) or other diagnostic tests for the evaluation of early, thin melanoma because they do not improve survival.

Studies show that there are no survival benefits from having an SLNB for patients with early, uncomplicated thin melanoma, such as melanoma in situ, T1a melanoma, or T1b melanoma ≤ 0.5 mm, Dr. Coldiron said. Furthermore, there is a very low risk of the cancer spreading to the lymph nodes or other parts of the body in these patients, who have a 97 percent five-year survival rate. “It is hard to argue for any invasive test that does not improve survival,” he said. In addition, patients are subjected to radioisotopes during the procedure and they can develop long-term edema and infections, especially when it is performed in the groin. In addition, the test is costly, ranging between $12,000 and $14,000.
Choosing Wisely, Dr. Schwarzenberger recalled.

The workgroup members agreed that it was important that the list reflect the breadth of practice, said Dr. Watson, who noted that developing the list involved a rigorous, objective process. “It was impossible to cover everything we do, but we wanted to touch on key areas,” she said. “Regardless of your practice, there is something you can take from the list.”

The workgroup members also focused on areas that had the greatest potential for overuse/misuse as well as the greatest potential for improvement in patient outcomes. They wanted the list to result in high-impact, easy-to-implement recommendations. Providers who follow these recommendations are expected to have a positive impact on the quality of health care and hopefully decrease the amount of money spent on it, Dr. Schwarzenberger said.

Given that non-dermatologists provide a great deal of dermatology care, the workgroup members wanted to make sure that the guidelines were not esoteric things that only dermatologists would understand, Dr. Watson noted. “They had to be things that were meaningful and understandable to family care doctors as well as patients,” she added.

**OTHER BENEFITS**

This list has the added benefit of helping educate patients about dermatologic care. Sometimes patients request tests and treatments that might not be necessary and it can be difficult to dissuade them. Physicians may feel as if they don’t have enough time to have lengthy conversations with their patients about the pros and cons of each test/treatment. Dermatologists can use this list as a way to educate patients about appropriate care, noted Brett Coldiron, MD, the Academy’s president-elect and a clinical assistant professor at the University of Cincinnati, who chaired the workgroup.

An unexpected benefit of the process was the opportunity to step back and think about the care that you provide on a daily basis and how you provide it, Dr. Chren said. Dr. Watson agreed. “It’s helpful as a specialty to take the time to debate and examine how we practice and ask how we can do better.”

This past March, the recommended list was reviewed and approved by the AAD’s Council on Science and Research as well as its Board of Directors. While workgroup members were pleased with the list, many hope it will not be the last. “As more evidence comes out, we should continue to question in order to deliver the best possible care for our patients,” Dr. Watson said. All of those involved with this effort had a very positive experience and are excited about the AAD’s participation in Choosing Wisely, Fischoff added. “The Academy would certainly consider developing another list.”

The current list is available online in two formats: for doctors, at www.aad.org/choosing-wisely, and for patients at www.aad.org/choosingwisely. *dw*

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**Do not treat uncomplicated, non-melanoma skin cancer <1 cm in size on the trunk and extremities with Mohs micrographic surgery.**

“This recommendation comes straight out of the appropriate use criteria for Mohs surgery,” Dr. Coldiron noted. [See www.aad.org/mohs-auc.] In healthy individuals, uncomplicated, low-risk, small (< 1cm), superficial, or non-aggressive squamous and basal cell carcinomas on the trunk and extremities can be treated with a simple excision, curette, or topical therapy in some cases, he said. In these areas of the body, the clinical benefits of this procedure do not exceed the potential risks. This recommendation will be helpful for explaining to patients who demand Mohs for non-melanoma skin cancers on their arms and legs that it is not recommended in those areas, he said.

**Do not use oral antibiotics for treatment of atopic dermatitis (AD) unless there is clinical evidence of infection.**

“It’s a knee-jerk reaction to prescribe oral antibiotics to treat atopic dermatitis, but there is no good evidence that it’s beneficial unless there is crusting, weeping, or active infection,” Dr. Coldiron said. Children and adults with AD commonly have high numbers of Staphylococcus aureus bacteria on their skin. While it is widely believed that S. aureus bacteria may play a role in causing skin inflammation, the routine use of oral antibiotics has not been shown to reduce the signs, symptoms, or severity of AD that is not infected. Without an indication of infection, he said, the use of oral antibiotics may lead to antibiotic resistance. Oral antibiotics are not only expensive; their use can cause side effects, including hypersensitivity reactions.

**Don’t routinely use topical antibiotics on a surgical wound.**

The use of topical antibiotics on clean surgical wounds has not been shown to reduce the rate of infection, said Dr. Coldiron, adding that this is one of his pet peeves. Moreover, topical antibiotics can aggravate open wounds and hinder the normal wound healing process. Their use can increase the risk of developing contact dermatitis, topical sensitization, and antibiotic resistance.

“All in all, these recommendations will save the public money as well as some morbidity and even mortality,” he concluded.
How are we dermatologists perceived by our medical colleagues — and by the public in general? The question has loomed large this year, and our Ad Hoc Task Force on Perceptions of Dermatology has been both assessing the results of a survey of our medical colleagues, as described in October’s cover story (see www.aad.org/dw/monthly/2013/october/a-matter-of-perception), and looking at ways to enhance our image.

How we are viewed by our fellow physicians takes on even greater significance as the nation grapples with health care reform and how to pay for physician services. If we are not perceived as critical partners in reducing the burden of disease, we risk being marginalized. The task force has identified several tactics that can improve the way we are viewed by both the medical community and the broader public. They fall into six categories: educating medical students, working with primary care, inpatient/hospital consultations, volunteerism, leadership, and a proactive communications strategy.

Many of these categories interrelate. For instance, a long-term project to make activity in the local medical community part of the residency experience and encourage residents to continue being active once they are in practice involves leadership training. Our Leadership Institute offers a variety of courses at the Annual Meeting to help dermatologists at all stages of their careers be more effective in their practices, in the house of medicine, and in their communities. These courses are clearly marked in the Advance Program Book you received in the mail last month.

As the various provisions of the Affordable Care Act are implemented, one area where the law’s impact is clearly being felt is in efforts by Medicare and many private payers to achieve better care coordination between primary care providers and specialists. These efforts require each of us to look carefully at our current referral relationships and how we can optimize them.

With an increasingly wide range of providers delivering dermatologic care, how do we ensure that patients get to the right provider at the right time? We are working on referral guidelines that can help dermatologists achieve this. Can we do more to ensure that patients who need our care are able to see us quickly once they’re referred? The Academy has been developing strategies for ensuring timely access to expert care by a dermatologist (see the sidebar to the October cover story on perception).

How do we ensure that dermatologists maintain their leadership role in the health care team? This requires active involvement as new paradigms for health care delivery are being developed. How do we ensure that our referring physicians get the information they need from us after we’ve seen a patient they referred? Each referral letter or chart note we return to our referral sources gives our image a boost and helps make the overall health care system more efficient. Integration of dermatology into multispecialty teams and participation in hospital and group practice committees helps to ensure the future of our specialty as reimbursement models begin to focus on global payments for episodes of care. Not all of us need to join multispecialty groups, but those who practice in those environments have unique opportunities to demonstrate our value to our colleagues. Each of us can contribute in different ways, as every opportunity to interact with another physician is an opportunity to demonstrate the value of our specialty.

Technology is making it possible to handle some referrals in ways some of us couldn’t imagine during residency. Teledermatology has tremendous potential to enhance our ability to provide care to underserved populations in rural and urban areas. It can also help address one of the major concerns raised by our medical colleagues — the difficulty of obtaining inpatient dermatology consultation. Teledermatology may offer a solution that provides the needed expertise without creating multiple-hour disruptions in our schedules to see a single patient. In August, the Board of Directors approved a pilot project to demonstrate the value of teledermatology in improving the ability of dermatologists to provide inpatient consultations.

There are many ways to help promote a positive image of our specialty. Volunteerism, as I discussed in my October column, is a great way to enrich yourself while serving others — and it makes you and the specialty look good as well. The AAD recently recruited a new senior director of integrated communications who will focus on optimizing our communications strategy to convey the unique value of specialty care to the public, our peers, purchasers, payers and policy makers. The Academy works to make sure the media covers the full scope of our field and highlights the good that we do; you can help by showing off the full scope of your talents, your engagement in the community, and your volunteer efforts.

We provide vital services to patients and the health care system, but unless those making decisions know about what we contribute, our future is at risk. We can each play a part to ensure that our skills and the role we play in reducing the burden of disease is properly understood and valued. dw
Looking back at greats a reminder of what matters

EXECUTIVE DIRECTOR’S REPORT

BY ELAINE WEISS, JD

AS THE ACADEMY CLOSES ITS 75TH YEAR, Dermatology World took a look back at pivotal greats in the profession (see p. 26). Because my first year as executive director draws to a close around this same time, I found the look back instructive.

The article recognizes five people. It could have been 10, or a dozen, or 75 — one for every year the Academy has been around. But even the five people selected show the breadth of dermatology and the way the specialty has grown and changed. Identifying unnamed diseases and discovering treatments for them; directing research and funding toward important conditions; pioneering a surgical technique to ensure the complete removal of skin cancer; developing and refining the diagnostic criteria that ensure that patients can get the care they need. The accomplishments we highlight this month run the gamut. They illustrate the wide range of paths available to dermatologists, the depth and complexity of the field — and the ability of an individual with a good idea and the drive to pursue it to open up his or her own, as-yet unimagined path.

As important as the contributions of the trailblazers are, though, it’s important to remember that for your patients, there’s no dermatologist more important than you.

We know Pillsbury as a pioneer; patients hear his name and think of a bag of flour. You are the face of the profession for your patients. You’re the lens through which they perceive our entire field (and just as the perception of dermatology by others in medicine is vital to its future, too is the specialty’s image among the public, as Dr. Elston discusses in his From the President column this month). Discussions of the specialty’s reputation can sometimes sound as if such a thing existed as a single entity, but in fact it is different in every community. And the difference-maker is you.

You don’t have to be a pioneer for your contributions to make a difference. That’s what I take away from this month’s celebration of dermatology’s past greats. What I see is evidence that individuals are the ones who really move the needle for the profession — not regulatory reform, not changes in the reimbursement rates, not any of the myriad threats we may see looming. Individuals like the ones we highlight this month — serious people dedicated to serving their patients — put dermatology on the map and broadened its horizons. And serious people dedicated to serving their patients — like you — will keep us on the map in the future.
JAAD publishes paper on psoriasis research gaps

READERS OF THE JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY are probably familiar with the AAD’s six-part guidelines of care for psoriasis and psoriatic arthritis, which were published in JAAD between 2008 and 2011 and are among the journal’s most-cited articles. The guidelines offer treatment algorithms, a clinical decision tree, and photos to help clinicians diagnose and treat the diseases. (A Web app version of the guidelines is available at www.aad.org/mobile-psoriasis.) They also offer a quick outline of gaps in psoriasis research.

The latter was only a cursory review of areas where more work is needed, however, so the work group that developed the guidelines wrote an additional article, “Research Gaps in Psoriasis: Opportunities for Future Studies.” The article, one of the first of its kind in dermatology, is currently available online at www.jaad.org/article/S0190-9622(13)00919-5/fulltext and will appear in an upcoming print edition of JAAD. In addition to giving dermatologists a sense of where further study is necessary, the authors hope it will encourage funding agencies and pharmaceutical companies to pursue research. Among the needs identified are:

- large, prospective epidemiological studies to determine the true prevalence and natural history of psoriasis;
- further molecular studies in psoriatic and psoriatic arthritis patients to understand the function of psoriasis susceptibility genes and to identify novel therapeutic targets;
- studies to examine the role of environmental factors in the development of psoriasis;
- further investigation of the relationship between psoriasis and cardio-metabolic disease;
- studies which examine the role of adjunctive therapies such as psychological interventions in appropriate patient groups; and
- studies to identify biomarkers of disease severity and treatment response to optimize patient therapy.

– Richard Nelson

Sulzberger-funded dermpath app available

THE DERMATOPATHOLOGY SMARTPHONE APPLICATION myDermPath has been made available for free to dermatologists on multiple platforms, including the existing iOS app and new Android and Web versions. The app integrates clinical features, histology, differential diagnosis, and treatment options for over 1,000 dermatologic diagnoses, special histologic differential diagnosis algorithms, and a growing library of over 1,900 annotated histological and clinical images, along with trivia functionality to help users study for the American Board of Dermatology’s exam. It is available for free thanks to the American Academy of Dermatology’s Sulzberger Institute for Dermatologic Education Committee, which provides grant support for innovative initiatives in education and technology.

The myDermPath app was created by Mt. Sinai School of Medicine dermatopathologist Rajendra Singh, MD, who wrote the algorithm that guides users to a final diagnosis through a series of questions about associated features. In addition, dermatologists have the option to skip the algorithm and search by diagnosis to access the histological and clinical descriptions with photos. The application is connected to PubMed for references and contains a section to add one’s own notes.

Another function contains a list of all the commonly ordered special stains, with a decision assistance feature and comparison tools. An extensive list of almost all possible immunohistochemical stains used in dermatopathology is available along with a separate diagnostic algorithm, as is a section on immunofluorescence.

Academy President Dirk Elston, MD, and dermatologists Tammie Ferringer, MD, and Eun Ji Kwon, MD, assisted with the build and expansion. More information on the latest updates to myDermPath can be found at www.mydermpath.com. More information about Sulzberger grants is available at www.aad.org/education/awards-grants-and-scholarships/sulzberger-institute-grant.

– John Carruthers
Obituary

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


William M. Kelly, MD, 80, Waverly, Iowa. Completed dermatology residency training at University of Texas-Southwestern Medical School. Died July 5.


Nancy Lee Page, MD, 69, Fair Oaks, Calif. Completed dermatology residency training at University of California-San Francisco. Died May 27.

Harold Otto Perry, MD, 92, Byron, Minn. Completed dermatology residency training at Mayo Clinic. Died Aug. 9.

Harry Leo Roth, MD, 86, San Francisco. Completed dermatology residency training at Mayo Clinic. Died April 20.

Rose Balline Saperstein, MD, 95, Beverly Hills, Calif. Completed dermatology residency training at New York University Medical Center. Died Sept. 1.

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 4014, Schaumburg, IL, 60168-4014, via fax at (847) 330-1090, or via email at mrc@aad.org.
Dermatologists help train Peace Corps volunteers

The Peace Corps, along with the U.S. government and Seed Global Health, recently launched the Global Health Service Partnership, an effort to expand the base of medical educators in countries with critical provider shortages. The program utilizes mid-career physician and nurse volunteers committed to a year of both direct volunteerism as providers and collaborating with local educators and health personnel to foster advances in the region’s ability to meet its own health care needs.

To bolster the ability of volunteers to recognize and treat dermatologic conditions, Georgetown University dermatologist Scott Norton, MD, MPH, and Georgetown resident Dominique Pichard, MD, distributed the American Academy of Dermatology’s laminated teaching cards to 31 Peace Corps physicians and nurses.

The presentation followed a training session in tropical dermatology by Dr. Norton. The volunteers — the first group to set out as officers of the newly created Global Health Service Partnership — will soon embark with dermatologic training and teaching cards to Malawi, Tanzania, and Uganda. Dr. Norton was invited to contribute as a dermatologist who had a long history with the Peace Corps, starting during his military career abroad and continuing in his present role at Georgetown. The dermatology training of these volunteers, he said, has already shown early results.

“As part of their training, the Peace Corps wanted these physicians to have training to take care of individuals in the case of any outbreaks of tropical disease,” Dr. Norton said. “I taught them about outbreaks of pellagra and one woman pointed to that outbreak as an example of what tropical disease is.”

The laminated cards can be requested by Academy members at www.aad.org/forms/laminatedcards/request/Default.aspx. — JOHN CARRUTHERS

Members Making A Difference: Steven Rosenberg, MD

DERMATOLOGIST RAISES SPECIALTY’S POLITICAL PROFILE

PALM BEACH, FLA., dermatologist Steven Rosenberg, MD, has long been active in both his specialty and the politics of his home state. As the only dermatologist on the Florida Board of Medicine — and the first one in over 30 years — he has been appointed by three different governors, and spends an estimated 250 hours a year as first vice chairman developing new rules and legislation, hearing disciplinary cases, and serving on multiple committees.

“There is satisfaction in contributing to the citizens and physicians of our state by helping to maintain the high standards that our profession should have.”

• Dr. Rosenberg's legislative activism started during his college years. “I went to college and medical school when the Vietnam War was going on and students were a lot more politically active than they are today,” he said. “When I first started practice, I noticed that there was an older practitioner who many legislators deferred to as an expert. I took note and decided to become involved myself.”

• “It’s an interesting opportunity to revisit general medicine, see what’s happening in the specialties, and interact with the attorneys who represent different aspects of the system,” Dr. Rosenberg said of his service. “There’s a tremendous amount of work, and a lot of responsibilities that go along with it. It’s done with a great deal of time, effort, and consideration by the board members.”

• “We have done a number of things that have protected patient access to dermatologists and made sure that they’re getting the most reliable care possible,” Dr. Rosenberg said. “I think that dermatologists appreciate the efforts we’ve been able to put forth.”

• In addition to his work for the state of Florida, Dr. Rosenberg serves on a number of Academy committees and has been a speaker at the ethics forum at the Annual Meeting.

• “Unfortunately, many doctors aren’t politically involved enough either by becoming elected or getting the ear of their legislators,” he said. “We don’t want insurance companies and pharmaceutical companies dictating the future of medicine. If 100 percent of doctors get involved, we don’t have these problems.”

— JOHN CARRUTHERS

To nominate a physician, visit www.aad.org/membersmakingadifference.

Media Highlight

In the October issue of Allure (circulation 1,165,392), “Out, Damned Spot,” dermatologists David Bank, MD, Vivian Bucay, MD, Zoe Draelos, MD, Patricia Farris, MD, Jeannette Graf, MD, Pearl Grimes, MD, Susan Taylor, MD, Joshua Zeichner, MD, and Jessica Wu, MD, highlight different pigmentation concerns and offer skin care tips and treatment options. You can find other stories of interest in the Academy’s monthly Media Update newsletter available in the Academy’s Media Relations Toolkit at www.aad.org/members/media-relations-toolkit. Media Update can keep you current on the stories your patients may see in the media and ask you about when they visit your office. — ROSE HOLCOMB
EXPLORING NEW HORIZONS

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CENTRAL FLORIDA DERMATOLOGY CENTER

Wonderful Dermatology opportunity in Central Florida for BC/BE Dermatologist

Central Florida Dermatology and Skin Cancer Center (CFD) is seeking a BE/BC Dermatologist and/or Derm-trained Dermatopathologist, interested in joining a successful and growing practice. CFD serves a growing community with offices in Winter Haven and Lake Wales. A physician who joins the practice will be busy immediately. We provide the very best for our patients through personalized patient experience and a world class operating environment.

A qualified candidate will enjoy a professional career that will allow for a balance of work-life and personal interest which are unique to the Winter Haven/Lake Wales area. This position offers a competitive salary structure, productivity bonus, health and dental benefits, partnership opportunities, a generous PTO schedule, malpractice coverage, CME, and licenses and membership dues.

CFD is currently staffed with a fellow trained Mohs surgeon, a B/C Dermatologist, and four mid-level extenders. We have an inhouse Mohs and Biopsy lab. The lab is CLIA certified and has CAP accreditation. CFD has secured a highly respected reputation in the Central Florida area, and is considered a go-to resource for Dermatology and Dermatological-Surgery care in the area.

We are seeking a highly motivated individual who has a strong work ethic, is conscientious, ethical, and committed to providing excellence in care. We are seeking individuals who have a strong interest in practicing medicine in the Central Florida area.

Please call Dan Lackey at (863) 293-2147 opt. 7, or email CV to Daniel@centralfldermatology.com. Visit us on the web at www.centralfldermatology.com

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FT/PT BC/BE medical and/or surgical dermatologist to join our busy, established practice. 10,000 sq. ft. state-of-the-art facility with CLIA-certified Mohs lab, comprehensive psoriasis treatment center, aesthetic laser center, and clinical research. Forward CV to practice administrator: joann@dundeedermatology.com

CHICAGO NORTHWEST SUBURBS

FT/PT BC/BE medical and/or surgical dermatologist to join our busy, established practice less than 10 miles south of Boston. Please send CV to skuiipers@adamsstreetderm.com

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BC/BE Dermatologist to join busy, well-established dermatology practice less than 10 miles south of Boston. Please send CV to skuiipers@adamsstreetderm.com.

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Cambridge Health Alliance Dermatology

Cambridge Health Alliance (CHA) is a nationally recognized, award winning public health system and we are currently recruiting dermatologists to establish a Dermatology Division within the Department of Medicine. CHA is a teaching affiliate of both Harvard Medical School and Tufts University Medical School.

Our well respected health system is comprised of three campuses and an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston’s Metro North Region. As we transition to becoming an Accountable Care Organization, dermatology services will be essential to the success of our Patient Centered Medical Home Model.

These positions are primarily clinical and will practice general dermatology in an ambulatory setting as well as inpatient and emergency department consultations. For the right candidate, leadership opportunities exist and we will consider either PT or FT. Ideal candidates will be BC, possess two years of post residency experience and substantial interest in building a Dermatology Division, developing quality improvement projects, Tele-dermatology services, as well as curriculum development for both medical student and resident education. Candidates must possess excellent clinical/communications skills, commitment towards our multicultural, underserved patient population and a strong interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

At CHA we offer a supportive and collegial environment with a strong infrastructure—including an EMR system, as well as the opportunity to work with dedicated colleagues committed to providing high quality health care to a diverse patient population. Excellent opportunities exist for teaching medical students/residents, and we strongly encourage both women and minorities to apply. Please forward CV’s to Laura Schofield, Director of Physician Recruitment, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge MA 02139. Telephone (617) 665-3555, Fax (617) 665-3553 or via e-mail: lschofield@challiance.org. EOE. www.challiance.org

New Hampshire

We are seeking a part or full time Dermatologist to join our group of ten Board Certified Dermatologists in a professionally run practice with Dermatopathology, Mohs, Medical Aesthetics, and consulting facial plastic surgeon. This opportunity would allow a highly qualified dermatologist to practice with excellent support staff in a collegial practice in New Hampshire with competitive salary, benefits and practice ownership. For more information, please contact: Greg Catt, MBA, Practice Administrator, at (919) 282-5536 or via e-mail: gcatt@centralderm.net. For more information, please contact: Greg Catt, MBA, Practice Administrator, at (919) 282-5536 or email to gregc@centralderm.net.

Southern New Jersey

Great opportunity for BC/BE dermatologist in Medford, NJ. Beautiful community near Philadelphia, PA and Cherry Hill, NJ. Well-established busy dermatology practice in a brand new facility, with associated medical spa. Opportunity for competitive salary, benefits, and practice ownership. FT/PT position available. Email inquiry or CV to suzanne@accentderma.com.

New York

FT/PT BC/BE dermatologist needed to join as associate. Excellent opportunity to join busy Plastic Surgery solo practice on LI. Forward CV to Job4cosmeticsurgery@gmail.com

Chapel Hill, North Carolina

Fantastic location! Central Dermatology Center, PA, is seeking a full or part time Dermatologist to join our group of six Board Certified Dermatologists and four physician assistants in a comprehensive practice that includes general dermatology, Mohs with office-based surgical rooms and Mohs lab, dermatopathology, lasers, phototherapy, and a successful medi-spa. Very close to University of North Carolina and Duke University. We desire a highly motivated individual who is committed to stellar patient care and has a strong work ethic. We provide excellent support staff and a collegial environment with competitive salary, benefits and practice ownership potential. Our website is www.centralderm.net. For more information, please contact: Greg Catt, MBA, Practice Administrator, at (919) 282-5536 or email to gregc@centralderm.net

Portland, Oregon

The Portland Clinic, a large partner-owned multi-specialty clinic, is seeking a BC/BE general dermatologist to join our eastside location. Please contact Jan Reid at (503) 221-0161 x4600 or email jreid@tpcllp.com.

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Nashville, Tennessee

The Division of Dermatology at Vanderbilt University, Nashville is initiating a search for Board Certified/Board Eligible Dermatologists with training and expertise in General Dermatology, Pediatric Dermatology and Dermatological research. Candidates should have a strong commitment to teaching and clinical care. Those with special interests in basic or translational research are encouraged to apply. Reply with CV and a summary of academic interests: George P. Stricklin, M.D., Ph.D., Vanderbilt Dermatology at One Hundred Oaks, 719 Thompson Lane, Suite 26300, Nashville, TN 37204. Positions will remain open until filled. Vanderbilt University is an Affirmative Action/Equal Opportunity Employer.

Northern Virginia

PT/FT BC/BE dermatologist needed for medical/cosmetic dermatology practice. Please contact (703) 867-6566 or fax resume to (703) 461-7887.

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UPCOMING DEADLINES FOR 2014 ISSUES:

- March* ..................... January 3
- April ....................... February 14
- May ....................... March 28
- June ....................... April 25
- July ....................... May 30
- August** ................. June 27
- September .............. July 25
- October .................. August 29

*Bonus distribution at the Annual Meeting in Denver, March 21-25
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