It’s true. Rosacea is complex and it’s with them for life. Finacea® treats the papules and pustules with associated erythema of mild to moderate rosacea. Although some reduction of erythema which was present in patients with papules and pustules of rosacea occurred in clinical studies, efficacy for treatment of erythema in rosacea in the absence of papules and pustules has not been evaluated.

You have made Finacea® the #1 Dermatologist-prescribed topical rosacea brand.1

INDICATION & USAGE
Finacea® (azelaic acid) Gel, 15% is indicated for topical treatment of inflammatory papules and pustules of mild to moderate rosacea. Although some reduction of erythema which was present in patients with papules and pustules of rosacea occurred in clinical studies, efficacy for treatment of erythema in rosacea in the absence of papules and pustules has not been evaluated.

IMPORTANT SAFETY INFORMATION
Skin irritation (e.g. pruritus, burning or stinging) may occur during use with Finacea®, usually during the first few weeks of treatment. If sensitivity or severe irritation develops and persists during use with Finacea®, discontinue use and institute appropriate therapy. There have been isolated reports of hypopigmentation after use of azelaic acid. Since azelaic acid has not been well studied in patients with dark complexion, monitor these patients for early signs of hypopigmentation.

Avoid contact with the eyes, mouth, and other mucous membranes. In case of eye exposure, wash eyes with large amounts of water. Wash hands immediately following application of Finacea®.

Avoid use of alcoholic cleansers, tinctures and astringents, abrasives and peeling agents. Avoid the use of occlusive dressings or wrappings.

In clinical trials with Finacea®, the most common treatment-related adverse events (AE’s) were: burning/stinging/tingling (29%), pruritus (11%), scaling/dry skin/xerosis (8%) and erythema/irritation (4%). Contact dermatitis, edema and acne were observed at frequencies of 1% or less.

Finacea® is for topical use only. It is not for ophthalmic, oral or intravaginal use. Patients should be reassessed if no improvement is observed upon completing 12 weeks of therapy.

Please see Brief Summary of full Prescribing Information on adjacent page.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

1. According to IMS NPA™ (National Prescription Audit) July 2010-October 2013
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6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the 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 practice. In two vehicle-controlled and one active-controlled U.S. clinical trials, treatment safety was monitored in 788 subjects who used twice-daily FINACEA Gel for 12 weeks (N=333) or 15 weeks (N=124), or the gel vehicle (N=331) for 12 weeks. In all three trials, the most common treatment-related adverse events were: burning/stinging/tingling (29%), pruritus (11%), scaling/dry skin/xerosis (8%) and erythema/irritation (4%). In the active-controlled trial, overall adverse reactions (including burning, stinging/tingling, dryness/tightness/scaling, itching, and erythema/irritation/redness) were 19.4% (24/124) for FINACEA Gel compared to 7.1% (9/127) for the active comparator gel at 15 weeks.

Table 1: Adverse Events Occurring in ≥1% of Subjects in the Rosacea Trials by Treatment Group and Maximum Intensity*

<table>
<thead>
<tr>
<th></th>
<th>FINACEA Gel, 15%</th>
<th>Vehicle N=331 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild n=99 (%)</td>
<td>Moderate n=61 (19%)</td>
</tr>
<tr>
<td>Burning/stinging/</td>
<td>71 (16%)</td>
<td>42 (9%)</td>
</tr>
<tr>
<td>tingling</td>
<td></td>
<td>17 (4%)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>29 (6%)</td>
<td>18 (4%)</td>
</tr>
<tr>
<td>Scaling/dry skin/</td>
<td>21 (5%)</td>
<td>10 (2%)</td>
</tr>
<tr>
<td>xerosis</td>
<td>31 (9%)</td>
<td>14 (4%)</td>
</tr>
<tr>
<td>Erythema/irritation</td>
<td>6 (1%)</td>
<td>7 (2%)</td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>2 (&lt;1%)</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>Edema</td>
<td>3 (1%)</td>
<td>2 (&lt;1%)</td>
</tr>
<tr>
<td>Acne</td>
<td>3 (1%)</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate n=27 (8%)</td>
<td>Moderate n=30 (9%)</td>
</tr>
<tr>
<td>Burning/stinging/</td>
<td>8 (2%)</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>tingling</td>
<td></td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>9 (3%)</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>Scaling/dry skin/</td>
<td>5 (1%)</td>
<td>14 (4%)</td>
</tr>
<tr>
<td>xerosis</td>
<td></td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Erythema/irritation</td>
<td>8 (2%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>1 (&lt;1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Edema</td>
<td>3 (1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Acne</td>
<td>1 (&lt;1%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

* Subjects may have ≥1 cutaneous adverse event; thus, the sum of the frequencies of preferred terms may exceed the number of subjects with at least 1 cutaneous adverse event.

In patients using azelaic acid formulations, the following adverse events have been reported: worsening of asthma, vitiligo, depigmentation, small depigmented spots, hypertrichosis, reddening (signs of keratosis pilaris) and exacerbation of recurrent herpes labialis.

Local Tolerability Studies
FINACEA Gel and its vehicle caused irritant reactions at the application site in human dermal safety studies. FINACEA Gel caused significantly more irritation than its vehicle in a cumulative irritation study. Some improvement in irritation was demonstrated over the course of the clinical trials, but this improvement might be attributed to subject dropouts. No phototoxicity or photoallergenicity were reported in human dermal safety studies.

6.2 Post-Marketing Experience
The following adverse reactions have been identified post approval of FINACEA Gel. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate the frequency or establish a causal relationship to drug exposure:

- Eyes: irritocyclitis upon accidental exposure of the eyes to FINACEA Gel

7 DRUG INTERACTIONS
There have been no formal studies of the interaction of FINACEA Gel with other drugs.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy
Teratogenic Effects: Pregnancy Category B
There are no adequate and well-controlled studies in pregnant women. Therefore, FINACEA Gel should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Dermal embryofetal developmental toxicology studies have not been performed with azelaic acid, 15% gel. Oral embryofetal developmental studies were conducted with azelaic acid in rats, rabbits, and cynomolgous monkeys. Azelaic acid was administered during the period of organogenesis in all three animal species. Embryotoxicity was observed in rats, rabbits, and monkeys at oral doses of azelaic acid that generated some maternal toxicity. Embryotoxicity was observed in rats given 2500 mg/kg/day (162 times the maximum recommended human dose (MRHD) based on body surface area (BSA)), rabbits given 150 or 500 mg/kg/day (19 or 65 times the MRHD based on BSA) and cynomolgous monkeys given 500 mg/kg/day (65 times the MRHD based on BSA) azelaic acid. No teratogenic effects were observed in the oral embryofetal developmental studies conducted in rats, rabbits and cynomolgous monkeys.

An oral peri- and post-natal developmental study was conducted in rats. Azelaic acid was administered from gestational day 15 through day 21 postpartum up to a dose level of 2500 mg/kg/day. Embryotoxicity was observed in rats at an oral dose of 2500 mg/kg/day (162 times the MRHD based on BSA) that generated some maternal toxicity. In addition, slight disturbances in the post-natal development of fetuses was noted in rats at oral doses that generated some maternal toxicity (500 and 2500 mg/kg/day; 32 and 162 times the MRHD based on BSA). No effects on sexual maturation of the fetuses were noted in this study.

8.3 Nursing Mothers
It is not known whether azelaic acid is excreted in human milk; however, in vitro studies using equilibrium dialysis were conducted to assess the potential for human milk partitioning. The studies demonstrated that, at an azelaic acid concentration of 25 µg/mL, the milk/plasma distribution coefficient was 0.7 and the milk/buffer distribution was 1.0. These data indicate that passage of drug into maternal milk may occur. Since less than 4% of a topically applied dose of 20% azelaic acid cream is systemically absorbed, the uptake of azelaic acid into maternal milk is not expected to cause a significant change from baseline azelaic acid levels in the milk. Nevertheless, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use
Safety and effectiveness of FINACEA Gel in pediatric patients have not been established.

8.5 Geriatric Use
Clinical studies of FINACEA Gel did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects.

17 PATIENT COUNSELING INFORMATION
Inform patients using FINACEA Gel of the following information and instructions:

Use only as directed by your physician.
- For external use only.
- Before applying FINACEA Gel, cleanse affected area(s) with a very mild soap or a soapless cleansing lotion and pat dry with a soft towel.
- Avoid use of alcoholic cleansers, tinctures and astringents, abrasives and peeling agents.
- Avoid contact with the eyes, mouth and other mucous membranes. If FINACEA Gel does come in contact with the eyes, wash the eyes with large amounts of water and consult a physician if eye irritation persists. [see Adverse Reactions (6.2)].
- Avoid the use of occlusive dressings or wrappings.
- Skin irritation (i.e. pruritus, burning or stinging) may occur during use of FINACEA Gel, usually during the first few weeks of treatment. If sensitivity or severe irritation develops and persists, discontinue treatment and institute appropriate therapy.
- There have been isolated reports of hypopigmentation after use of azelaic acid. Since azelaic acid has not been well studied in patients with dark complexion, monitor these patients for early signs of hypopigmentation.
- Eye and Mucous Membranes Irritation
Avoid contact with the eyes, mouth and other mucous membranes. If FINACEA Gel does come in contact with the eyes, wash the eyes with large amounts of water and consult a physician if eye irritation persists. [see Adverse Reactions (6.2)].

For Dermatologic Use Only—Not for Ophthalmic, Oral, or Intravaginal Use
Rx only
DEAR READERS,

‘How is dermatology going to fare in the future?’

Don’t you wish that you knew the answer? Don’t you wish that you had the clarity of vision to weather the bumpy times that medicine is going through? It would certainly simplify matters. Think about how sweet it would be to know when the stock market was heading up instead of down.

In many spheres of life predictions of the future are possible if we take a step back and digest what is happening in our midst. Anticipating the future of dermatology, I think, is one of those circumstances where the future can be pieced together if we just take our heads out of the sand and pool our collective wisdom. We at DW felt that this is so important that we’ve created a whole issue about the future of dermatology, even added an additional feature story, so that we can look at it from several sides. You are going to want to be sure to read each and every piece this month to learn where our colleagues think that we are heading.

You will notice that there are two pieces this month that deal with ACOs — that is not an accident. ACOs are present in many parts of the country and will be coming soon to the rest. Our legal piece provides guidance on what to ask these organizations as they approach your practices. Just the very size of some of these organizations can be intimidating. So knowing what to ask to gain a thorough understanding of the organization is critical. A leap into a swimming pool is a much better step than a leap off a gangplank. Our second piece on this topic is our feature on what dermatologists think that practices will look like in the future. The dermatologists we spoke with see groups becoming increasingly the norm, and derms focusing more and more on collaborating with others outside of dermatology. They also see the incorporation of midlevel providers into our practices as we struggle to care for a growing number of patients.

You will also want to read our piece on fee-for-service and what its future looks like. While it is popular to predict its upcoming demise, we don’t see that happening so fast. With quality reporting squarely based on the fee-for-service reimbursement model, we predict that it will remain in place for awhile. However, make no bones about it, it is changing. We anticipate that the future will have FFS reimbursement tied to quality reporting with performance and quality measures dictating the payout. Think of your local gas station. If you pay cash you get a cheaper price; those paying with credit cards encounter a financial penalty.

And lastly take note of our pieces on how technology will help us in the future. One feature is about smartphones and how they will transform all of our practices as they become even more digital. We also have a feature on the future of treatments in dermatology — it describes how diagnostics and pharmaceutical agents are becoming more and more interfaced to understand and treat disease.

Some of what we write about will please you, while some may make you uncomfortable. The bumps on the road are big ones, no mistaking it. However, the only way to succeed is to understand the options and trends, and see if we can’t work to make the future a bright one for dermatology. The only other choice we have would be to walk around wishing that magically we’ll be okay, saying, “Mirror, mirror on the wall — please don’t let dermatology take a big fall.”

Enjoy your reading.
PROVEN RESULTS YOU CAN TRUST.

- Evaluated in 7 studies, on over 1,800 patients across 5 countries.
- After four weeks use of the moisturizing cream, patients used 39% less corticosteroids as skin conditions improved.
- 67% reduction in EASI scores at week 8.
- 72% improvement in Quality of Life scores at 12 weeks.

Studies conducted on patients 2 months to 65 years of age.

- Evaluated in 7 studies, on over 1,800 patients across 5 countries.
- After four weeks use of the moisturizing cream, patients used 39% less corticosteroids as skin conditions improved.
- 67% reduction in EASI scores at week 8.
- 72% improvement in Quality of Life scores at 12 weeks.

Studies conducted on patients 2 months to 65 years of age.

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special focus issue

26 THE FUTURE OF DERMATOLOGY PRACTICES
Dermatologists predict more collaboration, larger groups, fewer procedures in the near future
By John Carruthers

32 FEE-FOR-SERVICE LIVES ON — BUT FOR HOW LONG?
By Ruth Carol

38 IMAGINING THE FUTURE
Mobile technology, molecular medicine, and 3D bioprinting predicted to influence diagnosis and treatment
By Jan Bowers

46 THE DOCTOR IS IN ONLINE
Technology driving changes in the way appointments are made and how doctors “see” patients
By John Carruthers

“We’re only 1.5 – 2 percent of medicine, so we need to demonstrate value in the system.”

FROM THE EDITOR

CRACKING THE CODE
Pathology particulars.

ROUNDS
State Medicaid rules, more.

ACTA ERUDITORUM
Comparing therapies for pre-adolescent acne.

LEGALLY SPEAKING
What to ask if an ACO comes calling.

IN PRACTICE
Creating worlds.

FROM THE PRESIDENT

ACADEMY UPDATE
Election timeline, more.

ACCOLADES

FACTS AT YOUR FINGERTIPS
Projections show more non-physician clinicians in medicine’s future.
Psoriasis and Associated Comorbidities: Emerging Concepts

Join international opinion leaders for dinner and an interactive panel discussion

Embassy Suites Denver Downtown/Convention Center
1420 Stout Street
Denver, CO 80202
Cripple Creek Ballroom

Registration from 6:30 PM – 7:00 PM
Dinner served at 6:45 PM
Program from 7:00 PM – 8:45 PM

Friday, March 21, 2014

Introducing

The Psoriasis PACT is a group of international experts in the field of psoriasis brought together by Pfizer.

This program is independent and is not part of the official AAD Annual Meeting as planned by its Scientific Assembly Committee.
This program does not qualify for Continuing Medical Education Credit (CME).
Pathology particulars

BY ALEXANDER MILLER, MD

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

You submit a Mohs surgical excision specimen of a basal cell carcinoma on the nose for processing by your technician. As your goal is to most effectively distinguish benign adnexal structures, including basaloid follicular proliferation, from the basal cell carcinoma, you request that in addition to the routine hematoxylin and eosin stain your technician generate slides stained with toluidine blue. You then bill 17311 for the first stage of Mohs surgery and 88314 for the additional special histochemical stain. Is that appropriate?

The CPT specifies, both in the Mohs surgery and pathology coding sections, that Mohs surgery includes staining with a routine stain including hematoxylin and eosin and toluidine blue. Consequently, only 17311 is billable in the above scenario. When a different histochemical stain — for example, a trichrome stain — is used in Mohs surgery, CPT 88314, “histochemical stain on frozen tissue block,” may be billed to code for the additional stain done. The 59 modifier should be appended to the 88314 code, specifying that a distinct staining procedure from that included in the Mohs procedure was done. Code 88314 is reported for each frozen tissue special stain done, and once per each block of tissue stained. Thus, if there are several frozen tissue blocks stained with a special stain, 88314-59 would be billed once per each block. For example, if there are four Mohs tissue blocks stained with a trichrome stain, one would bill CPT 88314-59 x4 units. For Mohs surgery, a tissue block is defined in the CPT as “an individual tissue piece embedded in a mounting medium for sectioning.”

One may also request an immunoperoxidase stain, such as melan-A (MART-1), to be done during the course of Mohs surgery. This non-routine stain would be coded as CPT 88342 with a 59 modifier to specify the distinct, separately identifiable service. The 2014 CPT has revised the 88342 immunohistochemistry code language to include immunocytochemistry in the code definition. Additionally, the unit of service has been clarified. Previously, the unit of service was “each antibody.” For 2014, the CPT definition reads: “Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematoxylin stain; first separately identifiable antibody per slide.” If more than one antibody is applied to a single slide, a new add-on CPT code, 88343, is used to specify each additional distinct antibody applied to that slide. Unlike the 88314 special histochemical stain CPT code, which pertains only to frozen section tissue, immunohistochemistry CPT codes 88342 and 88343 are used for both frozen and paraffin fixed tissue slide material immunoperoxidase staining.

Special histochemical stains done on formalin-fixed tissue are coded with CPT 88312 and 88313. CPT 88312 pertains to stains done typically when searching for microorganisms. Such stains include Fite, methenamine silver, and Warthin Starry. CPT 88313 codes for all other special histochemical stains such as trichrome, iron, toluidine blue, alcin blue, and PAS. The unit of service for each of these CPT codes is the surgical pathology block.

**Example 1:** During the course of a Mohs surgery requiring three stages of tissue excision, with two tissue blocks in the first stage and one tissue block in the second and third stage, you request one special histochemical stain to be done on the first and second stage of tissue excision. You bill 17311 and 17312x2 for the Mohs surgery plus 88314-59x3 for the frozen section special stains.

**Answer:** Correct. One bills one unit of service for each special stain and for each block stained. As one special stain was used, and there were two tissue blocks in the first stage and one in the third stage, three units of special staining were done.
NOW AVAILABLE FROM VALEANT DERMATOLOGY: BENSAL HP®

Indications and Usage
An external treatment for the inflammation and irritation associated with many common forms of dermatitis, including certain eczematoid conditions. These conditions include complications associated with pyodermas. Indicated also in the treatment of insect bites, burns, and fungal infections.

Important Safety Information
• BENSAL HP is contraindicated for use in those patients who are hypersensitive to topical polyethylene glycols.
• BENSAL HP is for external use only. Not to be used in eyes.
• It is not known if BENSAL HP interacts with other topical medications applied to the treatment area. Use with other topical agents has not been studied.
• A small percentage of patients may experience a temporary burning sensation upon application of the ointment.
• Safety and effectiveness in pediatric patients has not been established.

Please see full Prescribing Information on the following page.


Bensa1 HP is a trademark of 7 Oaks Pharmaceutical Corporation used under license.
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DM/BHP/14/0003 Printed in USA.
DESCRIPTION: Bensal HP® ointment contains 30 mg salicylic acid per gram in a base containing: Benzoic acid, polyethylene glycol 400, polyethylene glycol 3350 and oak bark extract (QRB-7).

CLINICAL PHARMACOLOGY: The mechanism of action of Bensal HP® is not known. While the following animal data are available, their clinical significance is unknown. It has been demonstrated that Bensal HP® significantly reduces methicillin-resistant Staphylococcus aureus (MRSA) protected by biofilms in wounds using porcine models. In addition, Bensal HP® stimulates re-epithelialization of second-degree burns in porcine models.

CLINICAL STUDIES: A randomized, double-blind, placebo-controlled study evaluated the rate of wound re-epithelialization. Four partial-thickness wounds (2x2 cm & 0.2 mm deep) were created under local anesthesia on the thighs of 13 normal, healthy, male volunteers with an electrokeratome. Bensal HP® substantially increased the rate of re-epithelialization by 83% over the vehicle alone (p<0.01) and 77% over untreated control (p<0.005).

INDICATIONS AND USAGE: An external treatment for the inflammation and irritation associated with many common forms of dermatitis, including certain eczema-toid conditions. These conditions include complications associated with pyodermas. Indicated also in the treatment of insect bites, burns and fungal infections.

CONTRAINDICATIONS: Bensal HP® is contraindicated for use in those patients who are hypersensitive to topical polyethylene glycols.

PRECAUTIONS: For external use only. Not to be used in eyes.

DRUG INTERACTIONS: It is not known if Bensal HP® interacts with other topical medications applied to the treatment area. The use of Bensal HP® with other topical drugs has not been studied.

ADVERSE REACTIONS: Bensal HP® is generally well tolerated and non-irritating. A small percentage of patients may experience a temporary burning sensation upon application of the ointment.

DOSEAGE AND ADMINISTRATION: Patients should be advised to follow these step-by-step instructions for application of Bensal HP® Ointment:

1. Hands should be washed thoroughly. When using tubes, the tip of the tube should not come into contact with the area to be treated; the tube should be recapped tightly after each application. If applying with a cotton-tipped applicator, which is recommended, use once and discard.

2. Bensal HP® Ointment should be applied twice a day for best results.

3. Gently rinse the area to be treated with saline or water and then pat dry. Bensal HP® Ointment can be applied directly to the wound or placed on dry gauze and then placed on the wound. Wet Packs or Wet-To-Dry dressings are not recommended since they will dilute the ointment and decrease its effectiveness. Bensal HP® is designed to provide moisture to the wound.

4. Spread a generous quantity of Bensal HP® Ointment evenly over the desired area to yield a thin continuous layer of approximately 1/8 of an inch of thickness. There may be a mild warming sensation, or slight burning, to the treated area for 3-5 minutes after application. If irritation occurs or symptoms persist after 10 days, discontinue use and consult your physician.

5. Try to keep the area being treated clean and exposed to air when possible. Apply an appropriate dressing to shield the area from clothes or exposure to water or dirt.

6. If there is no improvement in the wound within 7 days, consult your physician for further evaluation of the wound. If there is no response to the ointment at all, then the wound should be re-evaluated for other contributing factors to the wound healing process.

PEDIATRIC USE: Safety and effectiveness in pediatric patients has not been established.

HOW SUPPLIED: Hands should be washed thoroughly.

Streptococcus agalactiae ATCC 13813 25,000

Staphylococcus epidermidis, ATCC 17917 12,500

It is important to apply the tube to the wound area to yield a thin continuous layer of approximately 1/8 of an inch of thickness.

Serratia marcesans, ATCC 13880 25,000

Salmonella typhi, ATCC 19430 25,000

Minimal Inhibitory Concentration Testing of QRB-7

Microorganism Microorganism

Staphylococcus aureus, ATCC 6538 25,000

Salmonella choleraesuis, ATCC 10708 25,000

* Enterococcus faecalis, ATCC 19433 50,000

Pseudomonas cepacia, ATCC 10956 3,125

Streptococcus epidermidis, ATCC 17917 12,500

Microalgae faecalis, ATCC 8750 25,000

Streptococcus uberis ATCC 27958 12,500

Escherichia coli, ATCC 25922 25,000

Klebsiella pneumonieae, ATCC 13883 25,000

Pseudomonas aeruginosa, ATCC 10145 25,000

Shigella flexneri type 1A ATCC 9199 12,500

Pseudomonas psuedomobilis, ATCC 29837 1,563

Streptococcus sanguis, ATCC 10556 12,500

Acinetobacter calcoaceticus, ATCC 17961 25,000

Pseudomonas putida, HTB isolate 12,500

Aeromonas sobria, ATCC 9071 25,000

Staphylococcus hominis, ATCC 27844 12,500

Staphylococcus haemolyticus, ATCC 29970 25,000

Staphylococcus epidermidis, ATCC 15592 25,000

Staphylococcus simulans, ATCC 27848 25,000

Micrococcus lylae, ATCC 27566 50,000

Streptococcus agalactiae ATCC 13813 12,500

Staphylococcus epidermidis, ATCC 15592 25,000

Pseudomonas alcaligenes, ATCC 14909 25,000

Klebsiella oxytoca, ATCC 15764 12,500

Manufactured by: Sonar Products Inc. • Carlsbad, NJ

For: 7 Oaks Pharmaceutical Corp. • Easley, SC • 877.723.6725

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Proteus mirabilis, ATCC 9240 25,000

Minimum Inhibitory Concentration Testing of QRB-7

The minimum inhibitory concentrations (MIC) of QRB-7 are listed below in parts per million (PPM)*.
**Example 2:** You excise a lentigo maligna melanoma on the face with two stages of Mohs surgery. Each stage was processed into three blocks of tissue. Slides from each block from both stages were separately stained with melan-A and HMB-45 immunoperoxidase stains. You then bill for the immunoperoxidase staining as 88342-59x6 for one stain and 88343-59x6 for the second stain.

**Answer: Incorrect.** The two stains were applied to separate slides. Consequently, 88343 is not appropriate, as it codes for more than one immunohistochemical stain applied to one and the same slide. As CPT 88342 codes for each individual antibody used per block, one would code 88342 with 6 units (tissue from a total of six blocks) for the melan-A stain and 88342 with an additional 6 units for the HMB-45 stain, for a total of 12 units of staining. The appropriate coding would be: 88342-59x12.

**Example 3:** You have a histology processing laboratory on your office premises. Your laboratory performs both the technical slide preparation component and the slide interpretation. You excise a broad skin lesion on a leg, process the formalin-fixed tissue into two portions on two separate blocks, and discover that it is an extensive granulomatous dermatitis. You then obtain PAS and Fite stains on sections from both blocks. You bill CPT 88305 for the one tissue specimen interpretation plus CPT 88313-59x4 for the two special stains.

**Answer: Correct.** Two special stains were done, and each of the two special stains was done on slide specimens from two tissue blocks. This generated a total of four billable units of service. The 59 modifier is used to distinguish the service provided separate from the 88305 global pathology code, and the x4 multiplier signifies the four units of service provided.

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**11306, NOT 17306**

A single-digit error can be a big problem in coding—or a coding column. In our January Cracking the Code, we used code 17306 when we meant 11306. The corrected example appears below. The full article, with the correction, is available at www.aad.org/dw/monthly/2014/january/malignant-destruction-coding.

**Example 2:** You shave off a 0.5 cm wide lesion suspicious for a basal cell carcinoma on the neck. The maximum diameter of the shave is 0.8 cm. You await the histopathologic diagnosis prior to submitting your bill. The histopathology confirms the presence of a basal cell carcinoma with cut tissue edges free of tumor. As you apparently fully treated the tumor, you bill CPT 17271, malignant destruction on the neck (lesion diameter 0.6 to 1.0 cm).

**Answer: Incorrect.** Although the lesion was fully removed, the procedure done does not fit the destruction code definition. The CPT Assistant, August 2009 issue, p. 7, specifies that destruction is “...not removal by excision or shaving of skin lesions using surgical instruments such as a knife, scalpel, or other similar tools.” Consequently, the appropriate CPT code is either biopsy, 11100, or shaving of epidermal or dermal lesion, 11306.
Telehealth coverage evolves with medium

STATE NEWS ROUNDUP

- STATE LAW REQUIRES MEDICAID AND PRIVATE INSURANCE COVERAGE FOR SOME TeleMEDICINE SERVICES
- STATE LAW REQUIRES MEDICAID COVERAGE FOR SOME TeleMEDICINE SERVICES
- STATE LAW REQUIRES PRIVATE INSURANCE COVERAGE FOR SOME TeleMEDICINE SERVICES
- NO REQUIRED COVERAGE

The map above illustrates which states offer Medicaid reimbursement for telemedicine services, which mandate some level of private insurance coverage for telemedicine, which do both, and which do neither. (Medicare reimbursement, while growing, is difficult to track due to the regionally-applied definition of “rural” that informs coverage; see the article that begins on p. 46).

The reimbursement landscape surrounding telemedicine continues to evolve. While some of the states still only support select services or require a live interactive encounter, many of the longstanding barriers have begun to disappear in some states. Beginning in January 2015, all new or renewed insurance contracts in Arizona must cover telemedicine services if that service would be covered through an in-office visit. In California, Colorado, Nebraska, Texas, and Vermont, no insurance plan can require that in-person contact occur between a physician and patient before payment is released.

At press time, 28 telemedicine bills were active in 14 states and the District of Columbia. In New York alone, five distinct telehealth-related bills have appeared in the state’s assembly and senate in 2014. Florida’s house and senate bills seek to better define “telemedicine services,” while Alaska’s bill seeks to extend telemedicine privileges to out-of-state practitioners. Washington’s would reduce compliance requirements on hospitals granting telemedicine privileges.

The American Academy of Dermatology Association has sent letters supporting the expansion of telemedicine in relation to recent bills in Ohio and New York, as well as the aforementioned Washington legislation. Learn more about the status of legislation in your state at www.aad.org/members/aada-advocacy/state-affairs/pending-state-legislation.

- JOHN CARRUTHERS

Remembering A. Bernard Ackerman

AS AN ARDENT ADMIRER of Bernie Ackerman and as one of the few chairs that ever had the privilege to have him in the faculty, I read with great interest the essay, “Pivotal Dermatologists,” in the December 2013 issue of Dermatology World (www.aad.org/dw/monthly/2013/december/pivotal-dermatologists-elevate-the-status-of-specialty). As the chair of the department of dermatology and cutaneous biology at Jefferson Medical College in Philadelphia, I would like to point out that Bernie was part of our department from 1993 to 1997, and it was here that he set up the Institute of Dermatopathology. He had a huge following of students, fellows, and international scholars who benefitted from his vision and wisdom.

I don’t doubt the accuracy of the memory of my friend, Sam Moschella, in reference to a 27-headed microscope. My own recollection is that when Bernie came to Philadelphia in 1993, he in his modest way demanded that we purchase the world’s largest microscope, a 21-headed state-of-the-art Olympus, which we, of course, did. When Bernie eventually left Philadelphia in 1997, because “he missed the vibrance of the Big Apple,” he went to New York and demanded “the world’s largest microscope,” a 22-header.

Bernie Ackerman was a unique, highly inspirational personality and teacher, fondly remembered by hundreds of his trainees around the world. May he rest in peace — his legacy continues.

Jouni Uitto, MD, PhD
Philadelphia

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.
Fractional Thoughts: Past, Present, and Future.

Fractional Past:
The Evolution of Skin Resurfacing
Rox Anderson, M.D.

Fractional Present:
The Science Underlying Fractional Laser Therapy & its Role in Skin Resurfacing
E Vic Ross, M.D.
Providing Patients HOPE
Nathan Uebelhoer, M.D.
The Rationale for Integrating Photo-Fractional Therapy into the Derm Office
Sabrina Fabi, M.D.

Fractional Future:
Inverse Fractional
Rox Anderson, M.D.
Fractional Therapies of the Future
Dieter Manstein M.D.
Q&A

DR. VAN VOORHEES: Let’s start by defining what ages you are talking about when you refer to preadolescent acne.

DR. CORDORO: First, thank you to Dr. Steve Feldman at Wake Forest for inviting me to collaborate on this project; it was Steve’s idea to query the National Ambulatory Medical Care Survey (NAMCS) database to explore the off-label use of acne medications in the pediatric population.

For this study, we defined “preadolescent” as ages 7 to 11 years and “adolescent” as ages 12 to 18 years. Other groups investigated were those less than 1 year (neonatal or infantile) and those 1-6 years (mid-childhood).

DR. VAN VOORHEES: Is the prevalence of this type of acne increasing?

DR. CORDORO: It certainly seems to be. Fleischer, Feldman, and their group at Wake Forest published data in Pediatric Dermatology in 2011 (28(6):645–648) from NAMCS that revealed a statistically significant decrease in the mean age of visits for acne by children over a 28-year period in the U.S., likely indicative of an earlier age of acne onset. This data also showed that visits for acne by children aged 6 to 8 years steadily increased over time from 1979 to 2007.

DR. VAN VOORHEES: Do we know why this might be occurring?

DR. CORDORO: There may be multiple explanations, including earlier recognition and better access to health care. Another possible cause of great importance, and one supported by evidence, is earlier onset of puberty. Several recent studies have found that children are entering puberty earlier than they have in past decades, determined by comparison of peak height velocity, Tanner staging, testicular volume, and other measurements of recent cohorts compared to pediatric cohorts from decades ago. The question of why children...
are entering puberty earlier is a topic of controversy and active research.

**DR. VAN VOORHEES:** Are all of the standard acne therapies for children reasonable for those who are younger than 12?

**DR. CORDORO:** Basically, yes. We prescribe topical antibiotics, topical retinoids, benzoyl peroxide, oral antibiotics, and even isotretinoin for children with acne who are less than 12 years old. The choice of agents in this age group is individualized and based on the same parameters considered in adults — the primary lesional morphology or type of acne (comedonal and/or inflammatory), severity, risk of permanent scarring, and distribution. Age is a consideration in terms of tolerance — pre-pubertal children are not generating a lot of oil, so they will not be able to tolerate daily use of topical keratolytics like retinoids or benzoyl peroxide (BPO). You can combat this by decreasing the frequency of application, limiting to lower concentrations of the active ingredient, and using non-comedogenic emollients.

**DR. VAN VOORHEES:** Can you remind us which treatments are approved and which are not?

**DR. CORDORO:** Most acne treatments are approved for patients 12 years and older, including oral isotretinoin, topical retinoids, and topical antibiotics including topical clindamycin, erythromycin, and benzoyl peroxide individually and in combination formulations. The primary exceptions include oral erythromycin, which has no age restrictions; tetracycline and doxycycline, approved for ages 8 years and older; adapalene/BPO gel, approved for ages 9 years and older; and a newer formulation of tretinoin gel 0.05 percent, approved for ages 10 years and older.

**DR. VAN VOORHEES:** Are there specific agents that should be avoided in this younger age group?

**DR. CORDORO:** It’s best to avoid topical salicylic acid in infants and very young children with acne given the low, but possible, risk of salicylism. Oral tetracyclines should not be given to treat acne in kids less than 8 years old because of effects on developing teeth. Otherwise, most acne medications can be used safely and effectively in children.

**DR. VAN VOORHEES:** Tell us about your study. What were the goals? What was the population that you studied?

**DR. CORDORO:** The goals of the study were to compare the therapies being prescribed to preadolescent patients with acne (defined in this study as ages 7 to 11 years) with those being prescribed to adolescent patients (ages 12 to 18 years) and to determine whether prescribing patterns differ between dermatologists and pediatricians.

**DR. VAN VOORHEES:** What were your findings? Which medications were typically used in this younger age patient?

**DR. CORDORO:** There were many interesting findings! I will limit my comments to the differences between pre-adolescents and adolescents in terms of medications prescribed and how this varied by specialty. We found that physicians prescribed a wide variety of FDA-approved and off-label medications to preadolescent patients with acne. Preadolescents overall were primarily prescribed topical treatments, with topical retinoids accounting for the largest percentage of prescribed topicals. The other most commonly prescribed medications to preadolescent patients were topical BPO and the combination of BPO/erythromycin. Minocycline was the most commonly prescribed oral antibiotic in this age group.

In comparison, the leading topical treatments prescribed to adolescents with acne were the same — retinoids and BPO, in a slightly different order of frequency. The most interesting finding was that isotretinoin was the most commonly prescribed oral medication in the adolescent age group, followed closely by minocycline. The isotretinoin finding was one of the few major disparities between the two groups. Although isotretinoin was prescribed to 18 percent of adolescent patients, it was used in only about 1 percent of preadolescents. I am rounding the numbers here and will do so throughout the interview to make things easier.

**DR. VAN VOORHEES:** Were there differences in the frequency of the use of any of the medications because of severity of acne?

**DR. CORDORO:** Unfortunately, it is impossible to know the rationale behind the observed prescribing practices because the severity of acne, lesional morphology, and other parameters such as affordability that would influence treatment choices are not recorded in the NAMCS database. The current study, as well as data previously published by Yentzer and colleagues (*Pediatr Dermatol* 2008;25:635–639) stratified according to specialty, suggest that differences in acne medication prescribing patterns between dermatologists and primary
Care physicians (PCPs) are particularly pronounced in preadolescent patients. Dermatologists frequently prescribe topical retinoids to this patient population, whereas PCPs prefer oral antibiotics. This data matches our clinic experience and identifies a potential knowledge gap in acne treatment among non-dermatologists. PCPs are seeing these patients frequently, yet many may be unaware of the rationale for use of various acne therapies. In light of the significant gap between demand for dermatology services and supply, we should do our best to educate our non-dermatologist colleagues on the basics of acne management.

**DR. VAN VOORHEES:** Were there differences in the frequency of the use of any of the medications because of safety concerns?

**DR. CORDORO:** Though it is impossible to know for sure, if we use isotretinoin as an example, we can reasonably speculate that PCPs may be hesitant to prescribe this medication for a variety of reasons; among them, lack of specialty knowledge as it relates to using this drug appropriately, safety concerns, the strict requirements of federal monitoring programs, and the need for frequent clinic visits and monitoring bloodwork. This does not explain why dermatologists who are familiar with this medication and are using it in teens are not using it in preadolescent patients. This could be due to simple mathematics — severe acne in preadolescents is uncommon; therefore, isotretinoin use in this population is uncommon. An alternative explanation is that safety concerns together with the hassle of the iPledge program may be limiting the use of isotretinoin in preteens regardless of disease severity or specialty.

**DR. VAN VOORHEES:** What percentage of patients was seen by pediatricians versus dermatologists versus other medical specialties?

**DR. CORDORO:** The differences depended on the age of the patients and were not too surprising. Overall, adolescent patients with acne saw dermatologists far more often than any other specialty whereas the youngest patients were more likely to see pediatricians. The details are very number-heavy, and I invite readers to refer to the manuscript, wherein there is a nice color-coded graphic detailing this information. In general terms, we found that pediatricians managed the majority of neonatal and infantile acne, while dermatologists, general and family practitioners, and ob/gyns managed only a quarter of patients in this age group. Pediatricians also saw the majority of the patients with mid-childhood acne (60 percent) but this age group was more likely to see a dermatologist (40 percent) than were infants. Again, I am rounding the numbers here. Dermatologists primarily managed preadolescent acne patients (38 percent) but pediatricians managed a similar percentage of these patients (34 percent) followed by general and family practitioners (26.0 percent). Adolescent patients were much more likely to see a dermatologist (67 percent) than a pediatrician or a general or family practitioner.

**DR. VAN VOORHEES:** Did your study suggest that the lack of FDA approval of a medication plays a role in what is chosen for acne care?

**DR. CORDORO:** Fortunately, no. This data suggests that all specialties seem to recognize that off-label prescribing is necessary given the limited range of FDA-approved treatments for preadolescent patients. dw

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**Dr. Cordoro** is associate professor of dermatology and pediatrics at the University of California, San Francisco. Her article was published in the November/December 2013 issue of *Pediatric Dermatology; Pediatr Dermatol. 2013 Nov-Dec;30(6):689-94. doi: 10.1111/pde.12201. Epub 2013 Jul 22.*
ZYCLARA®:
Efficacy for the Full Field Treatment of Actinic Keratosis

TREATS THE FULL FACE OR BALDING SCALP WITH A METERED DOSE PUMP.

Indication
ZYCLARA (imiquimod) Cream 3.75% is indicated for the topical treatment of clinically typical, visible or palpable actinic keratoses (AK) of the full face or balding scalp in immunocompetent adults.¹

Important Safety Information for ZYCLARA Cream
- Intense local skin reactions including skin weeping or erosion can occur after a few applications of ZYCLARA Cream and may require an interruption of dosing. ZYCLARA Cream has the potential to exacerbate inflammatory conditions of the skin, including chronic graft versus host disease.¹
- Administration of ZYCLARA Cream is not recommended until the skin is healed from any previous drug or surgical treatment.¹
- ZYCLARA Cream should be used with caution in patients with pre-existing autoimmune conditions because imiquimod activates immune cells.¹
- Exposure to sunlight (including sunlamps) should be avoided or minimized during use of ZYCLARA Cream. Patients should be warned to use protective clothing (e.g., hat) when using ZYCLARA Cream. Patients with sunburn should be advised not to use ZYCLARA Cream until fully recovered. Patients who may have considerable sun exposure, e.g. due to their occupation, and those patients with inherent sensitivity to sunlight should exercise caution when using ZYCLARA Cream.¹
- Avoid concomitant use of ZYCLARA Cream and any other imiquimod cream because of increased risk for adverse reactions.¹
- In clinical studies for actinic keratoses, the most common adverse events involved skin reactions in the application area including erythema, scabbing/crusting, flaking/scaling/dryness, edema, erosion/ulceration, and exudate. Most local skin reactions were rated as mild to moderate.¹

Please see Brief Summary of Full Prescribing Information on adjacent page.

References: ¹ ZYCLARA Cream Package Insert. Scottsdale, AZ: Medicis, the Dermatology Company; February 2012.

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DM/ZCL/13/0004
Local skin Reactions
Intense local skin reactions including skin weeping or erosion can occur following topical applications of ZYCLARA Cream and may require an interruption of dosing [see Dosage and Administration (2) and Adverse Reactions (6)]. ZYCLARA Cream contains the potential for exacerbating inflammatory conditions of the skin, including chronic graft versus host disease.

Selected inflammatory reactions of the female external genitalia can lead to severe vulvar swelling. Severe vulvar swelling can lead to urinary retention. Dosing should be interrupted or discontinued for severe vulvar edema. Administration of ZYCLARA Cream is not recommended until the skin is healed from any previous drug or surgical treatment.

Systemic Reactions
Flare of ZYCLARA Cream symptoms may occur, or may predate, local skin reactions and may include fatigue, nausea, fever, myalgias, arthralgias, malaise and chills. An interruption of dosing and an assessment of the patient should be considered [see Adverse Reactions (6)]. Lymphadenopathy occurred in 2% of subjects with actinic keratosis treated with ZYCLARA Cream, 3.75% in 3% of subjects treated with ZYCLARA Cream, 2.5% [see Adverse Reactions (6)]. This reaction resolved in all subjects in 4 weeks after completion of treatment.

Table 1: Selected Adverse Reactions Occurring in ≥2% of ZYCLARA-Treated Subjects and at a Greater Frequency Than with Vehicle in the Combined Studies (AK)

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>ZYCLARA Cream, 3.75% (N=150)</th>
<th>ZYCLARA Cream, 2.5% (N=160)</th>
<th>Vehicle (N=159)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>10 (8%)</td>
<td>3 (2%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>Application site pruritus</td>
<td>7 (4%)</td>
<td>6 (4%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>7 (4%)</td>
<td>2 (1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Nausea</td>
<td>6 (4%)</td>
<td>1 (1%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Influenza like illness</td>
<td>1 (1%)</td>
<td>0 (0%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Application site irritation</td>
<td>5 (3%)</td>
<td>4 (3%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>5 (3%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>4 (0%)</td>
<td>0 (0%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>4 (0%)</td>
<td>1 (1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>4 (0%)</td>
<td>0 (0%)</td>
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</tr>
<tr>
<td>Lymphadenopathy</td>
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</tr>
<tr>
<td>Oral herpes</td>
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</tr>
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<td>Arthralgia</td>
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<td>4 (3%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Chills</td>
<td>0 (0%)</td>
<td>3 (2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>3 (2%)</td>
<td>2 (1%)</td>
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</tr>
</tbody>
</table>

Local skin reactions were recorded as adverse reactions only if they were extended beyond the treatment area, if they required any medical intervention, or if they resulted in patient discontinuation from the study. The incidence and severity of selected local skin reactions are shown in Table 2.

Table 2: Local Skin Reactions in the Treatment Area in ZYCLARA-Treated Subjects as Assessed by the Investigator (AK)

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
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</thead>
<tbody>
<tr>
<td>Erythema</td>
<td>96%</td>
<td>96%</td>
<td>78%</td>
</tr>
<tr>
<td>Severe Erythema</td>
<td>25%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Scabbing/Crusting</td>
<td>93%</td>
<td>84%</td>
<td>45%</td>
</tr>
<tr>
<td>Severe Scabbing</td>
<td>93%</td>
<td>84%</td>
<td>45%</td>
</tr>
<tr>
<td>Severe Edema</td>
<td>75%</td>
<td>63%</td>
<td>19%</td>
</tr>
<tr>
<td>Severe Erosion/Ulceration</td>
<td>11%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Exudate</td>
<td>31%</td>
<td>39%</td>
<td>6%</td>
</tr>
<tr>
<td>Severe Exudate</td>
<td>6%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Scaling/Dryness</td>
<td>91%</td>
<td>88%</td>
<td>77%</td>
</tr>
<tr>
<td>Severe Scaling/Dryness</td>
<td>84%</td>
<td>61%</td>
<td>1%</td>
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* All Grades: mild, moderate or severe

Overall, in the clinical trials, 11% (17/160) of subjects in the ZYCLARA Cream, 2.5% arm, and 0% in the vehicle cream arm required rest periods due to adverse reactions in the face area.

Other adverse reactions observed in the clinical trials of a drug cannot be directly compared to dosages for ZYCLARA Cream because they contain the same active ingredient (imiquimod) and may increase the risk for and severity of systemic reactions.

Increased Risk of Adverse Reactions with Concomitant Imiquimod Use

Concomitant use of ZYCLARA Cream and any other imiquimod products, in the same treatment area, should be avoided since they contain the same active ingredient (imiquimod) and may increase the risk for and severity of local skin reactions.

The incidence of concomitant use of ZYCLARA Cream and any other imiquimod products has not been established and should be avoided since they contain the same active ingredient (imiquimod) and may increase the risk for and severity of systemic reactions.

Immun Cell Activation in Autimmune Disease

ZYCLARA Cream should be used with caution in patients with pre-existing autoimmune conditions because imiquimod activates immune cells [see Clinical Pharmacology (2)].

ADVERSE REACTIONS

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to dosages for ZYCLARA Cream and may not reflect the rates observed in practice.

Clinical Trials Experience: Actinic Keratosis

The data described below reflect exposure to ZYCLARA Cream or vehicle in 479 subjects enrolled in two double-blind, vehicle-controlled trials. Subjects applied up to two packets of ZYCLARA Cream or vehicle daily to the face for 2 weeks and then on a 2-week break to allow skin healing. Subjects then received ZYCLARA Cream for 2 weeks followed by a 2-week washout period. This cycle was repeated 3 times weekly for up to 16 weeks. Complete clearance (no AK lesions at a dose of 15 mg/kg/day) was observed in 4 of 25 subjects. Erythema was the most frequently reported adverse reaction from 2 studies in children with molluscum contagiosum. Similar to the studies conducted in adults, the most frequently reported reaction was erythema. No local skin reactions reported by imiquimod-treated subjects in the pediatric studies included erythema (28%), edema, scabbing/ crusting (5%), and edema (2%).

The incidence of local skin reactions in the treated area in ZYCLARA-Treated Subjects in ≥2% of Subjects and at a Greater Frequency Than with Vehicle in the Combined Studies (AK)

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What to ask if an ACO comes calling

BY ALICE G. GOSFIELD, ESQ. AND DANIEL F. SHAY, ESQ.

M any dermatologists are concerned about how to respond if an accountable care organization (ACO) approaches them for participation. What questions should be asked at the outset? What pitfalls lie in the ongoing operation? How do I get out if I do not like it?

A significant aspect of the confusion associated with these questions is the lack of a standard definition of what an ACO is. In the health reform legislation, Medicare is authorized to contract with entities that would have the ability to accept both Part-A and Part-B payment and pay them a portion of any shared savings at the conclusion of a three-year contractual period. The creation of Medicare ACOs is not mandatory. They are not even demonstration projects or pilots. This was simply an opportunity that was made available in the legislation. It is modeled heavily on the Medicare Group Practice Demonstration Project of several years earlier in which, while quality improved, very little by way of shared savings was made available to the participants. (For further reading on this point, see “Lessons from The Group Practice Demonstration Project — A Sobering Reflection.” N Engl J Med 2011; 365:1659-1661.)

There is considerable federal regulation addressing how to qualify as an ACO, as well as regulatory exemptions from Stark, anti-kickback, and antitrust liabilities associated with otherwise disparate and independent providers coming together for this purpose.

But Medicare is not the only game in town. Commercial insurers have now begun to tout their entry into the ACO field. Here, there are no rules of the game nor common definitions. The basic feature is some form of altered payment, typically a shared savings bonus which is available based on measured performance both on quality metrics and financial results. Some of these ACOs are specialty-specific (e.g. a cardiology ACO or an orthopedic ACO), while other insurers expect the participating providers to play for all patients insured by that payer.
The theory behind ACOs is that by putting hospitals, physicians, skilled nursing facilities, and other providers under the same budget, their incentives will be better aligned than they are today, when physicians are paid on a fee-for-service basis and hospitals get paid predominantly based on diagnosis-related groups (DRGs) for inpatient care or Medicare’s ambulatory payment classifications (APCs) on the outpatient side. The hope is that the newly interrelated providers will develop infrastructure, processes, and expectations that define a different delivery system. The ACO becomes “accountable” by virtue of the financial risk in not meeting the defined budget as well as, typically, being subjected to quality measurement in order to qualify for additional dollars in shared savings or bonuses.

This article addresses some fundamental questions dermatologists should ask when presented with an ACO opportunity, offers some observations about the contracts that create the ACO, and also addresses some issues that arise under the typical bundled payment models used in ACOs.

**GOVERNANCE AND CULTURE**

A fundamental issue in considering whether to participate with an ACO is who sponsors and governs it. Many ACOs are formed as a result of collaboration between a health system and a payer, but data from Leavitt Partners in 2012 showed that physician-led groups were also getting involved. The differences in operations and policy can be substantial, although virtually all ACOs acknowledge the essential role of physicians. They may do so in different ways, however. If the ACO already has a payer contract that is a different proposition from an ACO that is beginning to coalesce in the hopes of getting a payer contract. Questions to ask include:

- Does the ACO have any contracts already?
- Who owns the ACO?
- Is it for-profit or not-for-profit?
- Who sits on the board?
- What are the operational committees through which the ACO program operates?
- Can you get copies of or access to all of the policies with which you would be expected to comply?

These are questions which will begin to reveal the culture of the organization. If the ACO is just forming, some dermatologists may be interested in getting involved in its development. Asking about those opportunities will matter to some physicians. Physicians who may be in independent practice in the community are sometimes concerned about the extent to which their viewpoint is represented in an ACO which is driven by a health system or a hospital. If this is a concern, ask about what the bylaws or policies say with respect to representation on the board and on significant policymaking committees. Are all the major decision makers from large groups or are slots maintained for independent community-based physicians, too?

The extent to which the ACO can be open and provide mission statements, compacts, or policy documents which state its goals and expectations can matter. Some ACOs are focused around really creating a new culture to deliver care. Others are more oriented solely around the terms of their payer contracts. There is no one answer as to which is a better setting for any dermatologist. That will depend on preferences as well as on how flexible the ACO is. Some may simply say “Here is our agreement. Sign it or not. We’ll find someone else if you don’t.” Others may be far more welcoming and inclusive.

**CONTRACTUAL ISSUES**

ACOs that are not single integrated delivery systems operate through a range of contracts. There is the contract from the payer to the ACO. Then there are the contracts which establish the multiple providers’, including physicians’, participation with the ACO. These ought to address criteria for initial and continued participation, the payment methodologies and formulae, and when payment is made. This is not very different from the issues that have been associated with joining any network, whether an IPA, a PHO, or even a managed care plan, since the ACO will be making payment to the participants in most instances. That is part of the point. The accountability in accountable care comes from the financial efficiencies of the payment model and quality scoring. Dermatologists should inquire as to whether they will be part of new payment opportunities and if so, what the metrics are against which they will be measured and scored.

The contract should address the bases for termination — by the physician as well as by the ACO. Some ACOs that select their participants very carefully to meet their cultural expectations may not allow without-cause termination without a fairly long notice period, because they have designed their network to have a specific constellation of providers. ACOs that are less discriminating in their choices may allow easier termination without cause.

Dispute resolution should also be addressed in the participation agreement. First there are the basic disputes around termination, payment, and application and adherence to the ACO’s articulated standards — whether
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practice guidelines, policies, or performance measure thresholds. ACOs are quite variable in the sophistication with which they address these issues. In addition, the fundamental payment incentives that make care more efficient and accountable raise new kinds of disputes than have existed before, as is discussed below. The essence of the ACO incentives is to bundle payment across disparate providers. This requires further inquiry.

**BUNDLED PAYMENT**

Bundled payment is the term that is used to describe arrangements where multiple providers who are organizationally separate are held accountable for their delivery of services under a single budget. The Medicare ACO Program is a bundled payment program with a sharing of savings at the end of a three-year period if quality benchmarks are met. As with most bundled payment programs, in Medicare's version providers are paid in the ordinary course of business in accordance with traditional payment models under Medicare Parts A and B.

Most standalone bundled payment programs are focused around episodes of care — one payment for a defined period of time. Where there is an admission involved, the episode usually includes some pre-admission care, the admission, and a period of time (from 30 to 180 days) post-discharge. While episode payments need not be bundled and can be paid to separate providers without shared risk, almost all current bundled payment models are based on episodes of care. Chronic care episodes (e.g., diabetes, asthma, hypertension) extend for a year to coincide with the payment of insurance providers.

Some bundled payment programs, particularly where commercial ACOs are involved, base their budget for the ACO on prior years’ expenditures with the expectation of a reduction. Even if the ACO is specialty-specific rather than having to define specific bundles around condition-based episodes, the payer may say to the ACO, “If you reduce the amount we spent on cardiology services for you last year, you can share in the savings.”

For dermatologists, the most critical issue with respect to bundled payment is whether the dermatology services are in the bundle or outside the bundle. Dermatology has not been widely cited as a driver of the increase in healthcare costs that motivated the creation of ACOs and new payment models. Still, given the overall push for greater value, dermatologists will be expected to demonstrate efficiency, usually defined as lower costs. In some instances this will be a threshold to be included in the ACO network to begin with. In almost all ACOs, demonstrated efficiency will be required for dermatologists to remain in the ACO.

The disputes that arise under bundled payment can be different from those in traditional fee for service. Usually, if a physician is part of a bundled payment, the definition of what constitutes the bundle (which providers are included), the boundaries of an episode of care, the budget for the bundle, and the rules for when a bundle is triggered, broken, or expired are not subject to dispute resolution because these are what the payer or the ACO has established in designing the system. The rules for severity adjustment of the bundle for more complex patients are also part of the design. But it is important that questions such as whether a specific episode has been launched, whether it is properly severity-adjusted, the portion of budget that is available to any physician, and the scores which determined if a physician qualified for any upside benefit (e.g., shared savings or a bonus of some kind) should be subject to some kind of review or appeal if the physician disputes the decision of the ACO. This is a potentially critical issue if a dermatologist has the opportunity for additional payment from this model. In some instances, it is possible that dermatologists could share in downside risk as well, but these rules ought to be stated in unequivocal terms in the participation agreement or its supporting policy documents or manuals.

**CONCLUSION**

There is no question that ACOs are proliferating around the country. Whether any dermatologist will face the question of whether to join is very market-specific. Once an opportunity is offered, its implications to any practice, how fair it is, and how much risk is at hand are quite variable. Evaluating these opportunities and managing participation in them is a significant contractual issue. Dermatologists should evaluate these opportunities carefully and with sophisticated guidance from experts.
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THE NEXT DIMENSION
Creating worlds

BY DAVID BIRO, MD, PHD

Are you ever so immersed in a piece of art that time seems to stop, a chill runs down your spine, and you become obsessed with the idea of creating something equally beautiful yourself? I get this feeling whenever I read a great book. Ever since I became hooked on novels in high school, I’ve always wanted to write one of my own.

PURSUING PASSION

My father was a doctor and as a result I grew up thinking about medical school. But I also felt an undeniable pull towards literature. I majored in the Classics as an undergraduate, drawn to the poetry and plays of the ancient Romans and Greeks more so than their history or architecture. It was during this time that I also read Somerset Maugham’s novel, *Of Human Bondage*. Phillip, the protagonist and Maugham’s alter ego, desperately wanted to be an artist but settled for medical school when his teacher expressed doubt about his creative abilities.

In my first year of medical school I began to think that I had settled too, and spent a good deal of time thinking of ways to escape. I would eventually take a leave of absence to pursue a PhD in literature at Oxford, a dream come true for me. For a while, I couldn’t have been happier, reading my favorite authors, going to lectures, and writing about the metaphors we use to express our most private experiences like pain.

At a certain point, however, I realized that the solitariness of a writing/academic life would not be enough for me. I needed more interaction with people and the belief that I was doing something more practical. I returned to medicine and soon began to embrace it with an enthusiasm I hadn’t known previously. I had made the right choice all along.

FINDING BALANCE

What I would come to realize was that my dual passions were not mutually exclusive. Eventually, I completed my doctorate during dermatology residency and decided that I would continue to write and practice just like some of my newer literary heroes, Abraham Verghese and Oliver Sacks. (See the sidebar for a few of my favorite books.)
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A second major interruption on the road to becoming a full-fledged physician occurred at the end of my residency when I was diagnosed with a rare bone marrow disorder and had to have a bone marrow transplant. The experience provided the raw material for my first two books of non-fiction: One Hundred Days: My Unexpected Journey from Doctor to Patient and The Language of Pain: Finding Words, Compassion, and Relief.

I have been practicing dermatology for almost 20 years now and finally found the perfect schedule. After taking my twin fifth grade boys to school, I write until noon and then go to the office and see patients for the rest of the day. The satisfaction I receive from solving medical puzzles and helping people never wanes. The writing part of my life, however, is not always so rosy. I spent years on my first novel that no one wanted to publish. Still, despite the rejections, I’ve forged ahead and am just about finished with a second novel. Something drives me to keep going and I can’t stop — the desire to create an alternate world that others will want to spend time in. At this point, it may also be an unwillingness to fail.

I love variety in life. It’s what attracted me to dermatology. I see people of different ages and backgrounds, conditions that are serious and not so serious. I prescribe medicines and perform surgery and am constantly learning new things. And I’m writing novels that I hope will move others as they have moved me. I feel very fortunate to be able to pursue the two great intellectual loves of my life.

**DR. BIRO’S FAVORITE BOOKS**

*Of Human Bondage*, Somerset Maugham

*Cloud Atlas*, David Mitchell

*The Man Who Mistook His Wife for a Hat*, Oliver Sacks

*My Own Country*, Abraham Verghese

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The Future of Dermatology Practices
The Affordable Care Act (ACA) became law four years ago this month, but dermatologists are just beginning to understand how the law will impact the way they practice, and while there are a range of opinions among the dermatology community, nothing is certain. Dermatologists who have been carefully monitoring the health system’s changes over recent years predict the new look of the specialty in the coming years will involve more patients, more non-physician clinicians to see them, more coordination of care among multiple providers, even within the specialty, and significantly more dermatologists practicing in group settings. >>
A NEW POPULATION OF PATIENTS
While dealing with an existing workforce shortage, dermatologists are also poised to face increased demand from a significantly expanded patient population. The Congressional Budget Office estimates that the ACA will reduce the number of uninsured from 48 million to 23 million between 2014 and 2024. Of those obtaining coverage, 12 million are expected to purchase insurance through health insurance exchanges like healthcare.gov, while 13 million will be newly covered through the Medicaid expansion. The White House places the estimate of uninsured who will be extended coverage at 30 million. Even if those estimates are optimistic, the challenges of so many newly insured patients seeking care will be significant for an overextended provider base, though not necessarily unprecedented, according to Mayo Clinic dermatologist Randall K. Roenigk, MD.

“Obviously, some of those 30 million or so uninsured will want to be seen by dermatologists, and many of our issues going forward will involve extending services to those who were, until recently, uninsured,” Dr. Roenigk said.

Regulatory mandates will increasingly drive the people who are coming out of residency into group practices to manage those issues for them.

“The comparison between the ACA and the introduction of Medicare in 1965 is a good thing to remember. In the end, the patients didn’t overwhelm the system, and suddenly doctors were getting paid for treating patients who weren’t able to pay for treatment in the past.”

The deadline to obtain coverage for citizens who do not currently have insurance or meet exemption requirements is set for March 31, when the open enrollment period ends. Following this deadline, the government can fine individuals who have failed to find coverage up to 1 percent of a household’s annual income. (This penalty will rise to 2.5 percent of income by 2016 and will be assessed through income tax filing.) Those not covered by the Medicaid expansion will be eligible for subsidies to help pay for their health insurance if they are at 133 to 400 percent of the federal poverty level, which was set at $11,490 for an individual and $23,550 for a family of four in 2013.

NON-PHYSICIAN CLINICIANS AND THE DERMATOLOGY WORKFORCE
While the physician workforce remains flat, non-physician clinicians (NPCs), both physician assistants (PAs) and nurse practitioners (NPs), have and will continue to see significant increases in numbers. This will make them a major player in the future of health care delivery, according to Brett Coldiron, MD, who takes office as Academy president this month.

“When you’re seeing all these new PAs and NPs, and no new doctors, it’s obvious they’re going to be providing a lot of care going forward,” Dr. Coldiron said. “If they’re part of our team, properly supervised, there’s no issue. But we’ll also see a lot of physicians setting up PAs and NPs in their own offices with remote or very minimal supervision.” Such arrangements are contrary to the delegation and supervision language in the Academy’s position statement on the practice of dermatology; see www.aad.org/Forms/Policies/ps.aspx for details.

An Agency for Healthcare Research and Quality-supported study in Public Health Reports predicted a 72 percent growth in the number of PAs by 2025, and a recent study in Medical Care predicted that the number of NPs will increase by 130 percent for the period between 2008 and 2025. A full 40.9 percent of dermatology practices reported employing either a PA or NP in 2012, and the number is projected to grow as demand for services does.

According to Mark Lebwohl, MD, a member of the Academy’s Board of Directors and its 2014 president-elect, cautiously integrating these NPCs into the practice of dermatology will help stabilize the specialty going forward. He notes that the Academy is considering ways to better serve dermatology practices employing NPCs. While still in early stages, that effort is focused on practices where NPCs work under direct, on-site supervision of a dermatologist and would provide the dermatologists in those practices with help ensuring that the NPCs who work for them are able to remain up-to-date. “There’s fairly widespread support on the Board and with the membership for that,” Dr. Lebwohl said.

Physicians may have to look for help in areas beyond hiring and training NPCs to manage the increased administrative burden that has also developed as they manage these patients. But current scope of practice rules appear to be inconsistent with increasing regulatory demands on physicians, according to Alexa Kimball, MD, MPH, professor and vice chair of dermatology at Harvard Medical School and Massachusetts General Hospital. Resolving that conflict, she said, will be key to determining the future of dermatology practices.

“The regulations to date ironically prohibit areas where other providers and staff can be involved in care, while increasing what physicians have to do. They haven’t really given physicians a break in how they have to ultimately document, record, and take responsibility for what has occurred in a patient visit,” Dr. Kimball said. “So what we’re seeing is scope of practice definitions — even down to what medical assistants are allowed to do — coming head to head against regulatory and administrative burden issues for their supervising physicians. It’s becoming much more difficult for physicians to practice, especially in high-volume specialties like ours.”
THE END OF SOLO PRACTICE?

Though the most common practice setting for dermatologists was, for years, solo practice, the membership data collected by the Academy has shown a slow but steady decline in solo practitioners. In 2005, according to the Academy’s Dermatology Practice Profile Survey, 44 percent of dermatologists reported practicing solo. By 2012, that number had declined to 38 percent, with more dermatologists joining dermatology groups or going into academics. What is, at present, a small trickle out of the traditional practice model could turn to a flood of solo dermatologists leaving the workforce as older soloists retire, while younger soloists may choose to join groups and academic centers.

Retirees will be replaced by younger physicians who have demonstrated more predilection toward becoming employees, Dr. Roenigk suggested. Newer generations of physicians, he said, are placing more focus on work-life balance and less on entrepreneurial independence.

“For 10 or maybe 20 of my years at Mayo, we always had openings for dermatologists in our Health System practices in rural Minnesota. It was tough to recruit those positions,” he said. “We’ve seen so much more interest in health system jobs across the country in the last decade. People more and more want to be employees, make a steady salary, and be done with work when they clock out.”

Another factor driving dermatologists to consider options other than solo practice, according to Dr. Kimball, is the administrative and regulatory burden on practices, which make joining a group more cost-effective from a management standpoint.

“Why hire a half-time equivalent person to manage meaningful use when you can hire one person for 20 people? Figuring it out for one provider is essentially the same as figuring it out for 20,” Dr. Kimball said. “Those regulatory mandates will increasingly drive the people who are coming out of residency into group practices to manage those issues for them.”

While she admitted that this might often be framed as a negative scenario, Dr. Kimball said that the end result of more dermatologists pooling resources and efforts in groups is likely to be dermatologists spending more time on the practice of dermatology, rather than administrative headaches.

A third pressure on the solo practice of dermatology, according to Dr. Coldiron, is the larger health system under the ACA generally disincentivizing solo specialty practice by physicians. The present market pressure, he said, has moved from the government and insurance companies toward the providers. This pressure, he said, includes not just quality reporting and EHR requirements, but lower reimbursements for common procedures creating economic disincentives for solo practitioners. But physicians who cut back on money-losing services or stop taking certain insurance, he

HOW TO FAIL AT HEALTH REFORM

Kevin Fickenscher, MD, CEO of the American Medical Informatics Association, spoke on the topic of change and adaptability during last year’s Academy health policy retreat. As part of his talk, he detailed his 10 ways to fail at transitioning to the new reality of the health system. Internalizing these lessons, he said, will help medical practitioners adopt the mindset required to successfully transition to a new era of medicine.

1. Stick with fee-for-service and become a high-priced outlier in a market increasingly dominated by price sensitivity.
2. Focus on controlling all of the resources rather than coordinating all of the resources to drive efficiency and effectiveness.
3. Focus on prevention and preventive services without focusing on the implementation of a new prevention-oriented business model for sustaining the organization.
4. Use the same skills that were successful in helping you build your old way of providing care delivery to build a new business of accountable care delivery.
5. Resist the transformation of health care from the closed, priestly-oriented guilds to an open health framework.
6. Don’t segment the health care market based on demographics and other differentiating factors.
7. Forget to focus on the low-hanging fruit.
8. Focus on individual performance rather than team performance — function as individuals and ignore working as a unit and ignore metrics and cost analysis.
9. Maintain a pyramidal approach to the care delivery process by continuing the same workflows and processes which have traditionally been utilized in care delivery.
10. Ignore social media and other evolving communication technologies as adjuncts in the care delivery process.
said, will be portrayed as rapacious and self-serving. For young dermatologists carrying hundreds of thousands of dollars worth of medical school debt, the risk of facing these conditions alone may soon be too great for most to consider.

“The overwhelming force, now with the ACA but before with meaningful use and PQRS, is toward solo physicians forming groups,” Dr. Coldiron said. “As a young doctor just coming into dermatology, you’re far better off forming or joining a larger dermatology group than going it alone. I don’t know how a solo doctor would be able to keep up with the administrative burden and still practice while reimbursements decline.”

THE NEW DERMATOLOGY PRACTICE
Keeping these developments in mind, the overall question remains — what will the dermatology practice of the future look like? While many opinions differ, most of them begin from the assumption that it will differ strikingly from our current picture of dermatology, and may involve more virtual visits, more subspecialization and coordination between subspecialists, and new payment models that reward outcomes.

A team-based approach (see last month’s cover story, “Team Approach,” at www.aad.org/dw/monthly/2014/february/team-approach) is one of the more agreed-upon tenets of health delivery going forward. But even further, Scottsdale, Ariz. dermatologist W. Patrick Davey, MD, MBA, a member of the Academy’s Council on Government Affairs, Health Policy, and Practice as well as that Council’s Workgroup on Innovations in Payment and Delivery and chair of the Practice Management Committee, sees a future where providers — even dermatology subspecialists — coordinate on a single patient and their record.

AADA DEFENDS DERMATOLOGIC SURGERY, DERMATOPATHOLOGY
As the health care system evolves, the Academy has focused significant effort on ensuring the continued viability of two vital subspecialties in dermatology: dermatologic surgery and dermatopathology.

Dermatopathology is threatened by payment reductions; in its 2013 fee schedule, Medicare cut reimbursement for code 88305, an anatomic pathology code commonly used by dermatopathologists, by 33 percent, and private payers have also moved to cut payments for the service. Meanwhile, the Government Accountability Office issued a report in July 2013 that expressed concern that dermatologists, gastroenterologists, and urologists were inappropriately utilizing pathology services at a great cost to Medicare. The report concluded that self-referring physicians utilized pathology services at a much higher rate than those who refer pathology services to outside labs.

The American Academy of Dermatology Association (AADA) issued a statement expressing concern at the report and stating that the Academy remains committed to working with regulators to ensure that pathology services are used in appropriate and cost-effective manners. However, the report provided the impetus for the introduction of the Promoting Integrity in Medicare Act of 2013, which would close the self-referral exception to the Stark Law under which dermatologists are able to refer anatomic pathology services to their own practices. The AADA has joined with other specialty societies to explain to legislators how passage of the bill would undermine the provision of quality dermatologic care.

Dermatologic surgery, meanwhile, has faced challenges from a variety of fronts, including legislative proposals in some states that would require dermatologists to obtain hospital privileges in order to perform some office-based surgery. More recently, Medicare and many private payers have sought to lower reimbursement rates for some surgical procedures, particularly Mohs surgery. The Academy responded to these cuts and payer concerns about rising utilization rates for Mohs surgery by developing appropriate use criteria for Mohs; learn more at www.aad.org/mohsauc. The AADA uses the criteria in meetings with payers and legislators as it seeks to demonstrate the unique value of the care dermatologists provide and the fact that dermatologists are careful stewards of health care resources.

Issues regarding scope of practice and office-based surgery continue to be debated in various state legislatures. The Academy, in partnership with state dermatologic societies, continues to advocate for the right of dermatologists to perform surgical procedures in their offices in line with their training and expertise. – RICHARD NELSON
“I think there will be a team of dermatologists providing care. It may be sort of a virtual team that we have, with a Mohs surgeon in one office and a medical dermatologist in another area as part of a larger multispecialty team, virtually organized through networks,” Dr. Davey said. “What we’re seeing is having essentially an information exchange where I send information about dermatology, and the primary care doctors put the information into their system. We’ll have a pathologist coming in at the end to provide lab results, and everything will be mingled into a common chart.”

Dr. Coldiron also pointed to more specialization and group integration as the ideal future makeup of dermatology practices. Certain subspecialties, he said, will soon prove easier to embrace than traditional general dermatology for young dermatologists.

“A lot of the shift in dermatology away from general dermatology has been toward skin cancer. And some people bemoan that, but I think it’s not entirely unreasonable. You can cure it, which is rewarding, and the patients are grateful,” said Dr. Coldiron, whose own career has seen him move to focus exclusively on treating cancer with Mohs surgery. The move reflects a need to address an epidemic of skin cancer, he said. “Likewise, aesthetic dermatology continues to be in demand, and the 10,000 new baby boomers retiring every day have proven that they’ll pay to maintain their health and appearance longer. Large group practices in the future can address the public’s dermatologic needs and spread the risk and administrative burden.”

Dr. Roenigk predicts that current experimentation with payment models and discussion of reforming how physicians are reimbursed will lead, eventually, to dermatologists being paid for outcomes rather than on a fee-for-service basis. Navigating such a shift, he said, will require demonstrating outcomes in a tangible fashion, which will provide a new challenge to a high-volume specialty.

“We’re only 1.5 – 2 percent of medicine, so we need to demonstrate value in the system,” Dr. Roenigk said. “Incentivizing our surgeons and pathologists to do the right thing on a value basis will prevent regulators from deciding that we shouldn’t be self-referring pathology, or that we can’t do Mohs in our offices because it’s continuing to cost the system a lot.”

The Academy is currently working on a group practice blueprint that targets the five areas of the country with the most dermatologists in small groups and the highest number of ACOs, according to Dr. Coldiron. The project aims to create a tool to help members determine the cost to meet the applicable federal and state regulations in regards to forming a larger dermatology group. If successful, Dr. Coldiron said, this tool would allow dermatologists to fill in certain practice information and determine the economic feasibility of forming or joining a larger dermatology practice. This should eliminate the initial investigative costs normally associated with doing so, though it will not eliminate the eventual need for an attorney and/or outside consultant.

As these larger organizations form, Dr. Davey said, physicians are likely become part of the governance structure of their practices and health systems. Non-physician clinicians, he said, will be delegated most of the day-to-day procedural work while the physicians will coordinate care across provider networks and see patients with unique conditions, difficult cases, and complications. The ultimate value of physicians to their practice, health system, or network will be in the value of the outcomes their work generates rather than the number of procedures performed.

“We in dermatology need to think about effectiveness going forward — to focus on not just getting patients seen, but achieving high-quality positive outcomes for them in the most efficient manner possible,” Dr. Davey said. 

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NPS IN PRACTICE

While the dermatology workforce remains relatively constant from a physician standpoint, with a fixed number of residents completing their training each year, the number of nurse practitioners (NPs) is predicted to rise steadily through 2025, mirroring the expected increase in the number of patients with insurance. Many states grant NPs a great deal of autonomy. In the states highlighted below, NPs are licensed to evaluate patients, diagnose patients, and initiate and manage treatment [including some prescription rights] under the oversight of the state’s board of nursing.
If Mark Twain were a dermatologist living in this century, he would say that the rumors of the death of fee-for-service (FFS) have been greatly exaggerated.

It’s true that the FFS payment system is being slowly phased out, but it’s unlikely that it will be replaced entirely this year, next year, or even the year after that. Even as alternative payment models, including value-based payment, accountable care, and bundled payments, continue to be rolled out, FFS will likely play a role, albeit an increasingly smaller one, in physician reimbursement for the near future. This is especially true for specialists, including dermatologists, who remain — for now — on the periphery of the shift in payment mechanisms away from payment based on volume and toward payment based on results. >>
FEE-FOR-SERVICE LIVES ON — BUT FOR HOW LONG?

REIMBURSEMENT IN 2014

“All payers want to move beyond FFS, but nobody has figured out how to do so in a common-sense and easy-to-implement manner,” said Brent Moody, MD, who serves on the American Academy of Dermatology’s Workgroup on Innovations in Payment and Delivery. Consequently, FFS will remain the dominant payment model for dermatologists in 2014 and until more substantial health care reform takes place, he said.

One of the reasons that FFS will remain intact for a while is that it is the basis for pay-for-performance payment models used by both public and private payers. That includes the Physician Quality Reporting System (PQRS) and the Medicare Shared Savings Program (MSSP) as well as the nearly 500 accountable care organizations (ACOs) that have been established across the country since passage of the Affordable Care Act (ACA). However, as participation in these value-based programs moves from voluntary to mandatory, dermatologists will find it increasingly difficult to continue to be paid solely under the traditional FFS system, Dr. Moody cautioned.

Dermatologists who plan to be practicing for at least the next five years will need to participate in such pay-for-performance payment models, he said. For most dermatologists, opting out of Medicare and insurance plans altogether and maintaining a cash-based practice is not a viable option, Dr. Moody said, because the size of the “cash only” market is unknown and likely would not support more than a few dermatologists in any given market.

Oliver J. Wisco, DO, dermatology clinic chief at Keesler Medical Center in Mississippi, who serves on the Academy’s Workgroup on Innovations in Payment and Delivery and is chair of its Performance Measurement Task Force, concurs. “Fee-for-service won’t go away, but nobody has figured out how to do so in a common-sense and easy-to-implement manner,” said Brent Moody, MD, who serves on the American Academy of Dermatology’s Workgroup on Innovations in Payment and Delivery. Consequently, FFS will remain the dominant payment model for dermatologists in 2014 and until more substantial health care reform takes place, he said.

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Oliver J. Wisco, DO, dermatology clinic chief at Keesler Medical Center in Mississippi, who serves on the Academy’s Workgroup on Innovations in Payment and Delivery and is chair of its Performance Measurement Task Force, concurs. “Fee-for-service won’t go away, but how much you’ll get paid in the future will depend on how you’re performing on the outcomes-based measures that the different organizations will be collecting,” he said. Whether that compensation will come in the form of salary or a year-end bonus as part of shared savings remains to be seen.

PUBLIC PAYERS CALL FOR ACCOUNTABILITY

Fueled by more ACA provisions taking effect this year, the Centers for Medicare and Medicaid Services (CMS) and Congress are continuing down the path of holding physicians accountable for both cost and quality, Dr. Moody said.

For example, the value-based payment modifier (VBPM) is CMS’s attempt to establish a budget-neutral payment system that will be used to adjust physician fee schedule payments based on the quality and cost of care physicians deliver. The VBPM is expected to be phased in over a two-year period beginning in 2015. It’s confusing because CMS is trying to create measures based on billing codes combined with performance measures and then develop a formula for how much pay or what percentage of shared savings a physician will receive, Dr. Wisco said. “It’s

KEY DEFINITIONS

Accountable care organization: An ACO refers to a network of health care providers (doctors, hospitals, and other non-physician health care providers) who work together through various integration models to coordinate care. Both public and private payers have formed ACOs.

Fee-for-service: In the FFS model, providers are paid at negotiated rates for each individual service they provide for a single illness or course of treatment. FFS arrangements may include diagnosis-related group payments, per-diem payments, fixed procedure code-based fee schedules, claims-based payments adjusted for performance measures, discounted charges-based payments, and accompanying pay-for-performance incentives.

Bundled/global payments: In a bundled payment model, providers are paid a single, “bundled” payment that covers services provided during a single episode of care or over a specific period of time. An example of a bundled payment is a “global surgery period.” Similarly, a global payment model establishes spending targets to cover all of the expected costs for health care services to be delivered to a specific patient population during a said time period. If the cost of services is less than the bundled payment or budgeted amount and health care quality performance targets are reached, providers share in, or retain, the savings. But if the costs exceed the bundled payment or budgeted amount, providers are not compensated for the difference. These types of payment models shift some of the financial risk from payers to providers.

Pay for performance: In a pay-for-performance model, providers are compensated by the payer based on an evaluation of performance on process and/or outcomes measures. This compensation commonly comes in the form of a bonus in excess of the providers’ FFS compensation. In addition to data derived from administrative or claims data, the payer uses measures related to the quality and/or cost of care. Patient satisfaction data is increasingly playing a role, as well. Based on the data, the payer rates the provider according to its own criteria.
very unclear as to how CMS is going to do this,” he added. Dermatologists won’t be affected by the VBPM next year unless they belong to a large hospital group that reports on non-dermatology measures using the group reporting option. Eventually, though, the VBPM will be stratified into the different specialties, Dr. Wisco explained.

Then there is CMS’s Bundled Payments for Care Improvement initiative, which is unlikely to impact dermatology in the immediate future but could have ramifications down the line. Each of its four models involves organizations entering into payment arrangements that include financial and performance accountability for episodes of care. “Unlike PQRS, VBPM, and MSSP ACOs, this initiative really does aim to move beyond FFS,” Dr. Moody said. There are 48 episodes of care from which participants can choose along with relevant diagnosis-related groups, but none of those episodes really apply to dermatology, he noted.

PRIVATE PAYERS EMBRACE ACO MODELS

On the commercial side, private payers are embracing ACOs and other value-based payment models. Aetna has 32 accountable care agreements across the country; it expects to have 60 agreements by the end of 2014. Aetna also has 112 Medicare Advantage Provider Collaborations, 41 single-payer commercial patient-centered medical homes (PCMHs), eight multi-payer PCMHs, and 63 Medicaid PCMH agreements. Approximately 15 percent of Aetna’s medical spending is paid through some form of value-based contract, and its goal is to increase that to

ADDITIONAL PAYMENT ISSUES AFFECTING DERMATOLOGISTS

While payment models determine how dermatologists are compensated for the care they provide patients, other factors can impact, and potentially threaten, the viability of their practice. Among the latter are the narrowing of networks, exclusive contracts that utilize non-physician clinicians, and increasing co-pays. These have more potential to impact dermatologists this year than having their fees cut dramatically or any changes resulting from the formation of ACOs, according to Carl Johnson, MD, chair of the AAD’s Private Sector Advocacy Task Force and a member of its Health Care Finance Committee. As they craft plans for the ACA’s insurance exchanges, payers are narrowing their networks to include a limited number of specialists, including dermatologists. In the last quarter of 2013, thousands of physicians received termination notices from health plans across the country. Most notably, UnitedHealthcare cut physicians from its Medicare Advantage program in at least 10 states. These narrow-network plans may lack a sufficient number of dermatologists to adequately care for the beneficiaries, said Brent Moody, MD, who serves on the AAD’s Workgroup on Innovations in Payment and Delivery. In fact, payers have narrowed networks so much that some don’t have access to a Mohs surgeon, noted Scott Gottlieb, MD, from the American Enterprise Institute, in his testimony before the House Ways and Means Committee Subcommittee on Health in December 2013.

The narrower the network, the more control the payers have on costs. But tightening networks also helps to eliminate sicker patients who require more specialty care, Dr. Johnson explained. “If these patients can’t see their specialists in the plan, they’ll elect to move from the Advantage plan to a traditional Medicare plan, thus the Advantage plan will save money.” All specialists are being affected by these actions, not just dermatologists. Insurance companies say that they are using quality measures to tie payment to performance, Dr. Johnson said. But with so few dermatology-specific measures, there are not many ways to judge quality for dermatologists. Instead, they are really looking at data to see how often a physician sees certain patients and how expensive the medications he or she is prescribing are. Insurance companies view a physician who treats sicker patients who need to be seen more often and may require costly drugs to treat their conditions as being a bad physician, he said, but it’s also the definition of a specialist.

Large groups of specialists, including dermatologists, that negotiate exclusive, discounted contracts with payers is another trend that could affect dermatologists in solo or small practices. These groups can negotiate such deep discounts because they use physician assistants and nurse practitioners to see the patients, Dr. Johnson explained. Consequently, dermatologists in these groups are spending far less time with patients. In some states, such as Florida, he said that large groups of dermatologists are getting exclusive contracts. Finally, employer-based insurance plans are either cutting back on what services they are covering or increasing co-pays. “Increasing co-pays can discourage patients from seeing a specialist,” Dr. Johnson said.
more than 45 percent by 2017, according to a company spokesperson. Humana has more than 900 accountable care relationships with 30,000 providers and one million Medicare Advantage members across 40 states and Puerto Rico. It has 600,000 additional members participating in initial value-based arrangements. UnitedHealthcare has 15 ACOs with additional ones being launched in several states in 2014. UnitedHealthcare is working to significantly expand the use of accountable care contracts across its commercial, Medicare, and Medicaid businesses, according to a company spokesperson.

The appeal of ACOs in the private sector is that there is more leeway in how they can be designed, Dr. Moody explained. For example, private payers can offer benefits that encourage plan members to use network providers, affording them more direct control over costs; this is not permitted in Medicare ACOs.

Akin to Medicare’s Pioneer ACO contracts, Blue Cross, Blue Shield of Massachusetts (BCBSMA) has reached year five of its Alternative Quality Contract (AQC). In 2012, BCBSMA reported that payments for the care of more than 44 percent of its membership and 49 percent of its payments were made under global budget/payment arrangements. Being touted as a national model for payment reform, this contract model combines a per-patient global budget with significant performance incentives based on nationally endorsed measures of quality, effectiveness, and patient experience. The initial global budget is based on historical health care cost expenditure levels adjusted annually for inflation and patient health status. Providers can earn an additional 10 percent of their payment as part of performance incentives based on quality and safety metrics. Some AQC contracts are solely with physician groups, including specialists, while others are with delivery systems that include both physicians and hospitals.

The goal of the AQC is to reduce the medical expense trend of participating organizations by half over a five-year contract term. In a study published in Health Affairs in July 2012 (Health Aff July 2012 10.1377/hlthaff.2012.0327), AQC groups spent 3.3 percent less than FFS groups in the second year of the contract. In addition, AQC groups showed improvements in the quality of chronic care management, adult preventive care, and pediatric care. While 11 AQC groups participated in the study, the program has grown; there are currently 16 groups involved in AQCs.

Despite the growth of ACOs in both the public and private sectors, the vast majority of dermatologists involved in them are those practicing in university-based practices or large multi-specialty groups, noted Carl Johnson, MD, chair of the AAD’s Private Sector Advocacy Task Force and a member of its Health Care Finance Committee. If the ACOs prove to be a viable payment model in the long run, then they will need dermatologists to flesh out their panels, he said.

MOVING TOWARD OUTCOMES

While value-based payment systems currently determine quality largely using process measures (see www.aad.org/dw/monthly/2014/january/are-you-a-good-neighbor) they are expected to move to outcomes measures. This shift requires replacing administrative claims-based data collected largely from electronic health records (EHRs) with more robust clinical data, such as those derived from more advanced EHRs and clinical data registries, Dr. Moody said. It is now widely recognized that claims-based measures are insufficient to determine the quality of care people are receiving.

**NCQA PROGRAM RECOGNIZES SPECIALTY PRACTICES**

Last March, the National Committee for Quality Assurance (NCQA) launched a program that recognizes specialty practices committed to improving access, communication, and care coordination with primary care practices. The Patient-Centered Specialty Practice (PCSP) Recognition program is modeled on the agency’s Patient-Centered Medical Home Recognition program. The PCSP program recognizes specialty practices that:

- Establish agreements with primary care clinicians to exchange key information and establish coordinated care planning and management.
- Provide timely access to care and clinical advice based on patient need.
- Use a systematic approach to identify and track patients and coordinate care.
- Include the patient and family or caregiver (if appropriate) in planning and managing care.
- Work with a delivery/reimbursement model that focuses on outcomes and reduced duplication of services.
- Align with newly proposed physician delivery and payment models (e.g., ACOs, episodes of care, bundled payments).

To date, 64 organizations were early adopters of the PCSP program.
data are the easiest to collect, but they do not necessarily capture the complete picture of clinical care.

Later this year, the AAD expects to release two measure sets that will both include outcomes measures. The psoriasis measure set includes one outcomes-based measure and the non-melanoma skin cancer measure set has several outcomes-based measures, Dr. Wisco noted. These specialty-specific measures are in addition to the measures related to melanoma and biopsy follow-up that are already in the PQRS; the number of measures applicable to dermatology, which has been plagued with a dearth of measures, is slowly growing.

Dermatologists who would like to earn a 0.5 percent bonus from Medicare this year through PQRS must report on nine measures (one of which must be outcomes-based) that cover at least three National Quality Strategy domains. The domains associated with the measures are patient safety, person and caregiver-centered experience and outcomes, communication and care coordination, effective clinical care, community/population health, and efficiency and cost reduction.

This means that not all of the PQRS measures many dermatologists report will be dermatology-specific, Dr. Wisco said — and this affords dermatologists the opportunity to position themselves as an integral member of the physician team. For example, dermatologists need to demonstrate that they are providing coordinated care: some of the measures in the Academy’s registry product, including 138, melanoma coordination of care, and 265, biopsy follow-up, reflect a desire in the health care system to see more care coordination between specialists and primary care providers. “If you see a patient, you need to send a note back to the referring physician,” he said. “That seems basic, but not everyone does it.” An EHR system can help, but only if it is connected to the referring physician’s network.

Dermatologists can also do medication reconciliation, inform the patient about smoking cessation, and take his or her blood pressure to achieve a PQRS bonus. “These are easy to do and shouldn’t be overlooked,” he said. Moreover, they are quality metrics that are coming out in the PQRS and will eventually be monitored. “These tasks are part of basic prevention and they’re what we should be doing to show that we’re putting in an extra effort,” Dr. Wisco added.

In addition, in the future dermatologists will be able to choose a clinical data registry option for reporting measures on the PQRS. CMS is expected to release a list of approved registry entities, such as a certification board or collaborative, on its website this fall. The PQRS registry option may empower organizations to develop their own quality improvement programs, Dr. Wisco said. “They can incorporate everything from Maintenance of Certification to quality reporting to insurance reporting requirements. Large organizations will be able to create measures that are relevant to their systems and show how their physicians perform well and how everyone can achieve at a certain level.” Although it’s still unclear how this option, which is currently voluntary, will be rolled out, Dr. Wisco believes that it is a significant step in the right direction. “This option shows a newer innovative way of thinking that is going to open a lot more doors.”

**CHOOSING A PAYMENT MODEL**

In the meantime, choosing which performance-based payment model to join can be challenging. “The administrative burden of participating in multiple models and understanding all of their nuances and overlapping requirements can be a serious problem and barrier to physician participation,” Dr. Moody said. To minimize physician reluctance to participate in these new models, CMS will need to partner with medical societies to provide more educational and technical assistance for physicians. Additionally, CMS and maybe even Congress will need to revisit the rules governing these new payment models to ensure that they do not have duplicative reporting requirements, and that they do rely on valid and reliable metrics and methodologies, and offer more flexibility overall, he said, making them relevant and meaningful to a range of physician practice types and patient populations. Dr. Moody points out that many questions still remain about the intent of the law regarding whether specialists are required to have an exclusive contract with one ACO or can join more than one. These questions could result in access issues and other unintended consequences, he added. Dr. Moody expects the AAD will play a large role in member education, as well. (Indeed, the AAD has a variety of resources available for members grappling with questions about ACOs at www.aad.org/ACO.)

Despite FFS being around for the near future, dermatologists would be wise to evaluate the different value-based programs being offered by the various health plans in their respective markets to determine which best suits their practice style and limit the practice to those arrangements, Dr. Moody said.

Look at hospital systems and how they are tied into these payment mechanisms, Dr. Wisco advised. “Joining a well-run organization that offers shared savings could be beneficial.” But he cautioned not to be the first person to join a new payment model. “Keep an eye on how the rest of the specialists are participating. Dermatologists are still on the periphery,” Dr. Wisco concluded. “We need to watch and see how all of this unfolds.”
IMAGINING THE FUTURE

Mobile technology, molecular medicine, and 3D bioprinting predicted to influence diagnosis and treatment
The year 2020 is only six years away, but the accelerating rate of technological advancement and scientific discovery will likely bring dramatic changes in the practice of dermatology by that time. DW asked seven prominent physicians, representing several areas of expertise, to speculate about what dermatologic diagnosis and therapy might look like in 2020 and beyond.

TRENDS IN DIAGNOSIS

TECHNOLOGY THAT FACILITATES PATIENT-DOCTOR COMMUNICATION

Jack Lewin, MD, president and CEO of the Cardiovascular Research Foundation and chairman of the National Coalition on Health Care

Computer-aided diagnosis [and other applications of technology] will be a game-changer for doctors and patients. We’re going to be looking for ways to promote value, and utilizing information technology more and more to do that. We’re talking about going beyond electronic health records: we’re looking at clinical decision support attached to EHRs, and also interfaces with patients. Patients are going to have their own version of what their symptoms are, and they’ll be inputting some of their own information. >>
So both patients and doctors will be entering information about particular circumstances — either disease management, or a specific acute medical issue — that will allow us to reduce the disturbingly frequent rate of misdiagnosis and/or use of therapeutics that will not be helpful to a patient for a number of reasons: maybe because of their genetic individuality, maybe because of a history of allergy.

We’ll be able to get more value out of health care by virtue of these communication tools. It will be the patient’s choice of device and app; there is already a multiplicity of new apps developing. There are all kinds of ways we can get at becoming more accurate, and also more effective in producing value, which is better care at lower cost for everyone concerned.

Daniel M. Siegel, MD, clinical professor of dermatology at the State University of New York at Downstate School of Medicine and past president of the AAD

By 2020, we should be at a point where we’re practicing routine store-and-forward teledermatology on a common basis. It’s just a matter of time until patients can get a consumer version of a device where they stabilize the area they’re told to put it on, they hold still, a little sensor tells them when they’re steady enough, somebody hits the remote control, it captures the image, and it goes off to the doctor — I think that’s not too far down the road.

I can see a point where, from pretty much anywhere in the world, you could have an interactive call with a patient, and have the patient take their device, stick on a dermascope, and let you look at things just as you might in the office. You won’t have the tactile feedback, but even that might be coming at some point.

By 2030, we might see something we don’t see now; I think we’ll see it much sooner than that, and maybe even get to the point where we can fix things the way they did on Star Trek, and heal them right away, but diagnostically we’re getting there pretty fast. And that will mean fewer biopsies and more rapid and accurate diagnoses. I’m thinking that will be closer to 2030 than 2020.

Orit Markowitz, MD, assistant professor of dermatology at The Mount Sinai Medical Center

The best way to predict how things are going to look in the future is to take a look at how things have changed over last 10 to 20 years. If you look at where we were 20 years ago, we’ve made a leap from the clinical exam to using non-invasive technologies like dermoscopy. There is a movement toward non-invasive in general, because we want additional information before we cut the skin and do a biopsy.

So the question becomes, where do you go from here? That’s where some of these other non-invasive devices come into play. In addition to using these devices to look at the skin and decide whether something actually needs to be biopsied, we will also be trying to monitor treatment, and using the devices in clinical trials.

The two I’ve used are confocal microscopy and optical coherence tomography. Confocal microscopy, I think, is better for diagnosis than for treatment monitoring. It has a lot of cellular resolution, but the depth is only 3 micrometers; it’s good for visualizing changes in pigmented lesions. Optical coherence tomography is very good for lesion monitoring, including non-pigmented lesions; it sort of mimics what we would think an ultrasound of the skin looks like. It’s a black and white, almost flip-book animation of a vertical section, and it goes to about 2 mm of depth, so it’s significantly deeper but has less cellular resolution than confocal microscopy. That’s the device that we’re currently using to sort of monitor and understand better what some of the ideal non-invasive treatments for non-melanoma skin cancer are.

One other device is high-resolution ultrasound, which has been studied in clinical trials. It goes deeper into the epidermis and the dermis, but the deeper you go, the less cellular resolution you have. At Mount Sinai, Robert Bard is using high-resolution ultrasound to look at in-transit metastases and nodes.

Non-invasive imaging is the future; I think these types of devices will become much more commonly used. Of course, I’m a little bit biased because that’s where my work has been centered. If you look at what happened from 20 years ago to today, you see that this is where it went, and I just feel like that’s the direction we’ll have to head in.
I have had psoriasis for 20 years now. I have tried all steroids, creams and lotions and even tar baths. Nothing has cleared my psoriasis like Mushatts. R.B.

I got samples of Mushatt’s from my dermatologist to try. I was covered, but after constant treatment with Mushatts it has improved. My Dermatologist was impressed by such good results. L.D.B.

I have been free of psoriasis for some time but lately it has returned. Already (within one week) the intense itching is receding and I am much more comfortable. Mushatt’s is a god send. Thank you! B.K.

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IMAGINING THE FUTURE

DETECTING AND TREATING MELANOMA
Armand B. Cognetta Jr., MD, associate professor of dermatology at the Florida State University School of Medicine and the College of Medicine at the University of Florida

In five to 10 years, biopsy rates and biopsy ratios will be scrutinized by insurance companies and organized medicine as a metric for diagnostic accuracy and specificity. Dermoscopy and its various algorithms, as well as computer-aided devices, such as Melafind, will be used to enhance sensitivity and specificity. There will be increased use of total body photography and more observation of photos of lesions which were not biopsied but were felt to warrant closer scrutiny. [More dermatologists will follow] the recent trend established by Stuart Goldsmith and others to disregard “D for diameter” and substitute “D for dark” and add “E for evolution,” or change; the logic is that this will increase sensitivity over specificity.

Dr. Siegel
One thing that’s very intriguing is Melanoscan, an imaging technology created by [Connecticut dermatologist] Rhett Drugge. He has taken psoriasis light boxes and put in about 30 cameras. The patient goes in and does two poses (it only takes about a minute), and the photography captures the entire skin surface. What is interesting is that right now, his business model is having technicians look at this and do periodic updates and look for change. But imagine a computer powerful enough to match up every lesion and look for change automatically, even if you’re slouching one day, or you’ve put a little weight on. Or imagine an app for your iPhone where you mount it a certain way, hit the button, and you photograph yourself. Then it asks you to take a picture of a spot that has changed — say, a mole that was perfectly round but now is oval and has a notch in it. That technology exists now, and it’s called edge recognition technology. The application could be five to seven years in the future.

With melanoma drugs, it’s a brave new world out there. We’ve got the BRAF inhibitors and the MEK inhibitors, but it’s still such early days. Gradually, just as we’re getting more targeted with biologics, we’ll hopefully get to a point where we’ll have smaller molecules that won’t have all the toxicities of current drugs and that can really be targeted so that you can look at someone’s genome and the disease they’ve got and come up with medication that’s really customized for them.

Allan C. Halpern, MD, chief of the dermatology service at Memorial Sloan-Kettering Cancer Center

In terms of competing technologies that might prove to be better than Melafind, there are several out there under development. Will they be ready for prime time by 2020? My own sense is that it’s possible but not likely. But, will they be good enough for a first-pass screen to be used by patients over the Internet? Maybe. There are already over 100 iPhone apps for dermatology out there. So I think that by the year 2020, patients will be able to take reasonable-quality skin images and send them to the dermatologist; that’s going to be a big game-changer.

I would predict that the dermatology electronic medical record will be image-based, and that mobile imaging for dermatologic triage is going to be routine. And that the dermatologists themselves will, as a result, be seeing much more highly pre-selected patients. In order to maintain their relative expertise to the other professions, they will need to apply more cutting-edge technologies like confocal microscopy. Because of their clinical acumen, that’s where the insights are going to be, and that’s going to be what differentiates the dermatologist.

One of the biggest challenges that we have in dermatology is that while all of this imaging is going forward, no one has created standards for it. The International Skin Imaging Collaboration Melanoma Project is an effort to develop standards around technology, techniques, and terminology. We’re starting with melanoma, with the idea that if we get it right in melanoma it will be generalized to other areas of dermatology. I’m talking about at least agreeing what kind of cameras make sense to use and how to use them. And then how to describe what those images show.

It’s beginning to use technology for the low-hanging fruit while these fancier technologies develop that I think is where dermatology is going to be.

ADVANCES IN THERAPY

GENETICS AND MOLECULAR MEDICINE IN THE TREATMENT OF PSORIASIS
Johann Gudjonsson, MD, PhD, assistant professor of dermatology at the University of Michigan Medical School

Part of my work is translating the findings from genetic studies into the biology of psoriasis, determining how specific risk genes shape information on psoriasis and influence the inflammatory process. In the past six or seven years, there has been enormous progress in identifying the risk genes involved, with 36 risk genes identified to date, and that’s only the first step. Now we are working to actually translate those findings into biological context, determining how these mutations and risk variants influence the disease process.

I believe we’ll gain a much deeper understanding of what psoriasis actually is by mapping out the key pathways involved. It’s going to become more and more clear, and I think most people today agree, that it’s probably not a single disease entity, but more like a spectrum of overlapping diseases. Thus, there’s a large difference from one individual to the next in terms of how patients respond.
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to any given treatment, how many risk genes they carry, and the shape and direction of the inflammatory processes in psoriatic skin. I think within the next five to seven years we're going to be able to tie all of this together.

Many individuals have been looking toward pharmacogenomics to help identify specific genetic markers of treatment response. It is likely that this will be problematic, particularly because there are so many risk genes involved and so many potential combinations. Some of these combinations are going to be synergistic and others may be antagonistic, and may not always work together in terms of treatment response. As psoriasis is a disease that can fluctuate in disease activity and sometimes change in terms of clinical presentation, I think what's going to be more likely to be successful in terms of predicting treatment responses are specific markers in the inflamed skin, such as gene expression profiling. A lot of the work that is ongoing in my laboratory is geared toward this by mapping out qualitative and quantitative properties of the inflammatory network in psoriasis and attempting to use that as a predictor of treatment response.

It's a very exciting time in psoriasis research. Things have moved so quickly that just in the past five or six years we have gone from having only one single risk gene for psoriasis up to at least 36 genes. Although there are many hurdles to cross, I think in the end this work will translate to more effective treatments and, hopefully, some kind of a predictor of treatment response in patients.

SQUAMOUS CELL CARCINOMA
Dr. Cognetta
The role of cytokines in squamous cell carcinoma will be increasingly recognized and exploited as a potential role for therapy. We have long recognized that SCCs are often painful lesions as compared to their benign counterparts; it is likely that some type of cytokine has a role in this. The recognition that some SCCs exhibit pathergy, as do other inflammatory diseases such as psoriasis and pyoderma gangrenosum, suggests there may be a common denominator between them vis a vis the immune system.

COSMETIC TREATMENT
Jeffrey Dover, MD, associate clinical professor of dermatology at Yale University School of Medicine, adjunct professor of medicine (dermatology) at Dartmouth Medical School, and adjunct associate professor of dermatology at Brown Medical School
I think we'll start to take a more global approach to anti-aging; instead of fixing this line or that hollow, there will be ways to slow the aging process. It will probably be a few years from now, but there will be systemic agents that can be taken as a way to slow or reverse the aging process. We have very little right now — nothing, in fact that has been shown conclusively — that you can take by mouth to slow the aging process.

Down the road, there will be agents that we can apply to the skin — through gene therapy — which will alter our appearance in a subtle and positive way. We will have creams which down-regulate the expression of telangiectasia, lentigines, wrinkles, and sagging. And there's no reason why we won't have a product that you can apply to the skin to stop pattern baldness from ever developing. We should be able to — in our lifetimes — have a treatment that will prevent hair from falling out in both men and women as they age. The first development, which is right around the corner, is to clone and grow human hair in the laboratory, and to use this to transplant into areas of thinning.

Lasers will continue to get smaller, less expensive, more effective, and safer. And we'll use more and more energy-based systems to produce desirable effects. Radiofrequency devices are now being used to tighten skin and we're now using selective cold and high-frequency ultrasound to reduce localized areas of unwanted fat. The next group of devices will be even more reliable, smaller, solid state and smart diode-based technology. These smart lasers will sense and fire only at the target but not at the surrounding adjacent skin.

TISSUE SYNTHESIS
Dr. Siegel
[Regarding therapy for other disorders], there have been shots in the past at fusing tissues with lasers, as opposed to sewing. That may come to the fore again. We may come up with better biologic glues, or combinations of ultrasound and chemicals that may be used to heal wounds. Biochemically, we may find ways to turn genes on and off to get fat metabolized for us. Or if you have an older patient who is losing fat in their face, you could turn on the fat that's left in those areas to produce more. I suspect we'll discover ways to activate genes that we're not even thinking about now.

There are already a couple of variations on 3D bioprinting of human tissue. It's really experimental, and not being done commercially yet. There are a couple of cases you hear about every so often that make the science glossies, as opposed to our literature. But it's only a matter of time. If you have someone who has a bad burn or someone who has vitiligo, you can just have the 3D printer spitting the right cells out to the right places or building up structural things like collagen or cartilage. I think that's less likely to occur by 2020, but it is possible. Most of these neat technologies tend to not be evolutionary, gradual change, but one day someone pops up with something no one else has thought of, and it's a revolutionary change. You just don't know when dramatic change will come about. dw
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The doctor is **IN** ONLINE
Technology driving changes in the way appointments are made and how doctors “see” patients

The general public spends ever-greater amounts of time online, organizing and planning their lives. Shopping and banking have gone from errands to be run to trifles that can be completed in five minutes at a desk or on a phone screen. Medicine is also moving to the digital domain: Patients can take advantage of always-on connectivity to find a physician online, make an appointment, research information and treatments related to their conditions, and even get a consult from a specialist.

ONLINE APPOINTMENT SCHEDULING

Technology has allowed many medical practices to embrace online tools to fill their schedules. A handful of companies offer online appointment scheduling (much like restaurants use OpenTable.com) for a small fee. This can reduce the workload of a front desk, but more importantly, it can help practices fill last-minute cancellations and retain that revenue. Oliver Kharraz, MD, COO and founder of ZocDoc.com, one of those appointment-booking services, said that what used to be unthinkable for doctors to consider — online scheduling — has rapidly become an accepted paradigm in an era of larger practice, more patient demand, and an increasingly expectant population. >>
“There’s been a gradual resetting of expectations on the side of the patient through the fact that the entire rest of their lives is now happening electronically,” said Dr. Kharraz, who noted that ZocDoc sees five million unique users each month. “You shop on Amazon, book your flight on Orbitz, find a contractor on Angie’s List, and the expectation is increasingly that you can interact with any service provider on the Internet. It’s not a stretch that they’ll want to do that with their doctor.”

In an era of millions more patients being served by the same number of doctors, technological solutions will have to bridge much of the gap, Dr. Kharraz said. The average no-show and late cancellation rate for a typical physician is around 25 percent. ZocDoc puts those appointments back into the system, he said, allowing its providers to utilize more of their capacity, especially if the dermatologist or practice manager knows of a patient who needs or has expressed a desire for immediate care. These unclaimed cancellations, he said, act as a hidden supply of care.

THE EXPANSION OF TELEMEDICINE
Telemedicine is another once-marginal use of technology that is achieving growing acceptance in practice among dermatologists.

EHR: MEANINGFUL WORK TO BE DONE
The electronic health record (EHR) serves as more than just a patient record for many dermatologists. It also manages front and back office functions, handles consults, and serves as an e-prescribing portal. Yet years into their widespread integration into practices, many dermatologists still express the sentiment that EHR technology has not yet adapted to their needs.

With the implementation of the Affordable Care Act, the looming start of ICD-10 this October, and the beginning of meaningful use Stage 2, 2014 will serve as a significant indicator of the work left to be done on EHR technology, according to Mark Kaufmann, MD, chair of the Academy’s EHR Task Force.

“We’re at a crossroads. 2014 is going to be a very important year because there are so many things converging at one time,” Dr. Kaufmann said. “CMS is going to be very eager to see what happens in 2014 with the meaningful use program, and will adjust things accordingly.”

What’s troubling, he said, is the almost 20 percent dropout rate among users from stage 1 attestation in 2012 to the second year of the program. Further dropout, he said, is likely to be seen when the number of users who attested by the March 31, 2014 deadline for the 2013 year is reported. One of the factors he pointed to as problematic was a continued lack of interoperability between different vendors and systems.

University of Missouri dermatologist Karen Edison, MD, a member of the Academy’s Telemedicine Task Force, agreed, saying that the amount of consolidation taking place since the EHR mandate was put in place has been less than anticipated, to the detriment of interoperability.

“The EHR market is not as mature as some had hoped it might be at this point. I’m co-leader of our regional extension center, and we’re still working with about 30 different vendors just with our priority primary care providers. There’s not been as much consolidation and standardization as we’d like to see,” she said.

Dr. Edison did point to her home state’s health information network, Missouri Health Connection, funded by a federal stimulus package, as a reason to hope for interoperability during the next stages of meaningful use.

“Our health information network is going to be linking all of these provider EHRs so we can have more coordination of care and less care in separate silos. Some of the major vendors are looking at applications that go to image capture and sharing. It’s evolving pretty quickly,” Dr. Edison said. “There’s still a long way to go on interoperability, but the information networking programs that are just now getting their sea legs are going to make things a lot easier.”

To learn more about the stages of meaningful use, visit www.aad.org/members/practice-management-resources/hit-kit/ehr-incentives.
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dermatologists. While still a long way from universal acceptance by payers in all states, telemedicine has made great strides from its first uses in the early 1990s. Medicaid programs in more than 40 states currently reimburse some sort of telemedicine service — mostly the traditional live interactive model, though there is a push for reimbursement for the more dermatology-friendly store-and-forward system. (For more information, see State News Roundup, p. 10.) Part of that change, according to Karen Edison, MD, a current member of the Academy’s Telemedicine Task Force, is the elimination of doubt over a physician’s ability to glean accurate information from a teleconsult and recommend the correct course of treatment.

“Technologies have evolved and improved so much that there’s no longer any question about the quality of the digital images or the quality of the video conferencing in terms of our ability to see, make diagnoses, and recommend treatments,” she said. “The broader health care community as well as the health policy community has, in the last three to five years, awakened to the promise of the technology in improving health and health care for our patients.”

Dermatology has long been concerned with obtaining and storing patient images and information to track patient progress over the years. This, according to Karen Rheuban, MD, medical director of the University of Virginia’s office of telemedicine, makes dermatology the perfect partner to demonstrate the utility of telemedicine expansion.

“There’s a huge demand for telemedicine services that has only been increasing. Dermatologists have long been involved with image acquisition as part of their practice. In our digital world, there is no reason that digital photography can’t be part of the record, part of health information exchange, and expanded through telemedicine,” Dr. Rheuban said. “Not only is it a tool that can be integrated into everyday care, but store-and-forward has the potential to maximize the efficiency in terms of workflow and case management. A dermatologist could look at appropriately acquired images to determine the need for triage.”

University of Virginia dermatologist Kenneth Greer, MD, first began using telemedicine to offer consults to prisoners in the Virginia state penal system. The difficulty and logistics of getting a specialist to see high-risk prisoners led to a pioneering live interactive model. In the near future, he said, dermatologists may be able to generate further revenue by performing store-and-forward consults at the end of the day. The model, he said, offers more flexibility and less dependence on support personnel to work.

“Once the payers catch up, you’ll probably have individuals who sit down after office hours and do store-and-forward consults for a fee,” Dr. Greer said. “There’s the potential for it to be a bigger part of dermatology than live interactive telemedicine, where I depend on lighting, more equipment, and the support personnel.”

In late 2013, telemedicine received a much-needed boost from the Centers for Medicare and Medicaid Services (CMS) in the 2014 Medicare physician fee schedule. The new fee schedule expanded the geographic areas where telehealth services are covered by Medicare, from counties not defined as part of a metropolitan statistical area to a new standard defined by the Office of Rural Health Policy using a method called the Rural-Urban Commuting Area Code. This method, which is explained in greater detail at www.hrsa.gov/ruralhealth/policy/detail at www.hrsa.gov/ruralhealth/policy/definition_of_rural.html, defines roughly 91 percent of the area of the U.S., containing around 20 percent of the population, as rural. The change, Dr. Rheuban said, was long overdue.

“With telemedicine, Medicare’s definition of a ‘rural area’ where they would reimburse for E/M services was extremely challenging,” Dr. Rheuban said. “Under the definition that lasted through the end of 2013, the Grand Canyon was technically still in an ‘urban’ area that didn’t fall under coverage.”

The timeline of dermatology’s widespread embrace of telemedicine among individual practitioners, according to Des Moines, Iowa dermatologist Timothy G. Abrahamson, MD, will largely depend on the speed of CMS and private payers, who have until recently failed to recognize the parallels between patients in underserved areas and patients in remote states where telemedicine is more widely reimbursed. For instance, Medicare has reimbursed for store-and-forward telemedicine in Alaska and Hawaii for decade, he said.

“My thought would be that the simplest way to move forward with telemedicine is to pursue the same payment structure that Alaska and Hawaii have gotten for the same services. If the argument is rural access, the Alaskan experience said that most patients were an hour and a half away from access,” Dr. Abrahamson said. “In Des Moines,
I’ve regularly had patients come from two hours away. I’m not necessarily pushing for more, just the access to the established model of store-and-forward telemedicine as in Alaska and Hawaii.”

Dr. Abrahamson began a pilot program in January 2014 that allows for live interactive teledermatology for inpatients at one of the five hospitals at which he sees patients in the Des Moines area. The key for dermatologists, he said, will be in pursuing reimbursement for store-and-forward, which was previously only reimbursed by CMS in limited areas of the country that CMS, under the older definitions of the term “rural,” found to be the most remote and underserved.

With much of the onus of record-keeping being placed on medical providers, he also argued that store-and-forward consults could offer much better case documentation.

“You would be able to keep photos, or even a video, in the patient record for a year or two with a system similar to what radiologists use, and you could go back and see the data a provider used for their decision process,” Dr. Abrahamson said. “There’s access to better data with store-and-forward, and there’s more data potentially storable from the consult. It can help justify a service or decision much better.”

Presently, Dr. Edison said, teledermatology serves a very important function for many providers, allowing for

TECHNOLOGY TOUCHES ALL CORNERS OF PRACTICE

It’s no stretch to argue that apart from the system-wide changes mandated by the Affordable Care Act, the integration of constantly evolving technology has provided the most sweeping changes to medicine in the past decade. Electronic health records (EHR) continue to make inroads into practices, spurred along by incentive programs and the eventual mandated use of the technology. In integrated health systems, a single patient record can show documentation from a number of specialists.

Physicians now increasingly use smartphones to access high-quality research and communicate with colleagues and patients [J Med Internet Res. 2012 Sep-Oct; 14(5): e128] and 85 percent of residents training in ACGME programs reported using smartphones as part of their studies [J Med Syst. 2012 Oct; 36(5):3135-9]; uses included reading reference and textbook material, accessing treatment algorithms, and using coding and billing apps. In addition to making practice information easily accessible via HIPAA-compliant cloud computing (see “Using the cloud for data storage,” www.aad.org/dw/monthly/2014/february/using-the-cloud-for-data-storage), University of Pennsylvania dermatologist Carrie Kovarik, MD, chair of the Academy’s Telemedicine Task Force, said that computers have made nearly all the necessary literature and reference material available to the dermatologist in the exam room.

“Even just 10 years ago, I used to have to make photocopies of journals for patients, or have to refer to a bookshelf in my office for a difficult case or an explanation. Now I can sit with my computer and do a complete literature search in five minutes,” Dr. Kovarik said. “It’s only going to become more easily accessible to providers all over the globe.”

Consumer-focused technology also continues to grow at a surprising rate. The 2014 edition of annual Consumer Electronics Show in January, lately a showcase for smartphones and HDTVs, saw over 300 exhibitors showcase products and software for wellness and medical treatment — a 40 percent increase over the previous year’s show.

“The high number of medical equipment providers at CES tracks with the transformation in which every consumer is a digital consumer and every business is a digital business,” Accenture managing director of medical equipment technology John D. Korry wrote in a Jan. 7 article on FoxBusiness.com. “Connectivity is about using the cloud, analytics, and other technologies to transform the way health care is provided in an all-digital world.”
The doctor is
**ONLINE**

The expectation is increasingly that you can interact with any service provider on the Internet. **It’s not a stretch that patients want to do that with their doctor.**

answer on the severity of their skin condition within three business days from a board-certified dermatologist, along with a treatment plan or an in-office appointment for more serious cases.

“I think that there’s a fee-for-service model around teledermatology from patients themselves that may become popular — they’ll pay for access, and for convenience,” Dr. Edison said. “I don’t think fee-for-service is going away overnight. Even when we more fully adapt to a new model, there may be pockets of it that exist, and this could be one of them. Patients are willing to pay for access.”

Despite the promise of a streamlined visit and additional payment source, Dr. Edison is quick to point out that patient-centered care works best when health care can be delivered locally, if not regionally. It doesn’t particularly help the patient, she said, if a dermatologist makes a good diagnosis but the patient has no access to the treatments, pharmaceuticals, or testing necessary.

Seeing providers begin to act in concert with the technological tools available, said University of Pennsylvania dermatologist Carrie Kovarik, MD, chair of the Academy’s Telemedicine Task Force, demonstrates possible future practices for much of the specialty.

“Technology has already allowed patients to not necessarily travel to the doctor’s office to receive care. Whether it’s looking up results from a patient portal, or being able to receive treatment via a primary care office and teleconsult, it’s brought everything closer together,” she said. “We have patients who come to our office for follow-ups that could be done at a distance. If the patient is doing well, they could save a lot of time and money doing follow-up care via these new means.”

DIRECT-TO-PATIENT TELEDERMATOLOGY

Taking things a step further, some services offer patients direct access to a dermatologist without ever seeing any health care provider in person. According to Dr. Edison, of the more than 100,000 consumer-directed health apps in smartphone marketplaces, 26 relate directly to dermatology, and about a dozen claim to connect a user with dermatologists for photo consults.

DermatologistOnCall, for instance, allows patients to create an account, capture their own images, and get an answer on the severity of their skin condition within three business days from a board-certified dermatologist, along with a treatment plan or an in-office appointment for more serious cases.

**NEW TOOLS FOR TOMORROW**

Whether dermatologists see a patient in person, for a teleconsult requested by another provider, or through direct-access teledermatology, they may soon turn to photo recognition software to track changes in their patients’ conditions. While currently in its early stages, photo recognition, integrated into a patient record with captured images, could possibly process serial photos of lesions and recognize changes in those lesions over time and alert the physician to suspicious growth. Properly captured images, working in concert with a software algorithm, could also accurately estimate body surface area to help dermatologists track a patient’s progress, according to Dr. Kovarik.

To best advocate for reimbursement and safeguard the quality of care, Dr. Rheuban said, new standards will need to be developed and continually evaluated. The need is urgent, she said, because the widespread embrace of technology that allows for virtual visits and software solutions that recognize changes from visit to visit seems inevitable.

“If we’re going to advance the field, we need to have as many practice guidelines and standards for the acquisition of images and the delivery of care as possible. I want to do this in a thoughtful, careful way, but I would like the societies to weigh in on what the guidelines are for the delivery of care in that specialty,” she said. “Just like the radiology world developed DICOM as their standards, the various specialties need to determine what standards are most appropriate. Dermatologists themselves need to set the appropriate standards and have the flexibility to adapt as technology evolves.”
Upcoming CME Activities

Closure Course and Dermatologic Surgery: Focus on Skin Cancer

Hyatt Regency Tamaya Resort & Spa - Santa Ana Pueblo, New Mexico

May 21-22, 2014 - Closure Course
This intense learning experience will provide didactic instruction and practical demonstrations of multiple closure techniques, anatomic site-specific discussions, and valuable pearls, designed to take dermatologists to the next level of derm surgery practice. An elective lab session featuring realistic visco elastic models will allow registrants to practice new and more complex closures, proctored by highly experienced Mohs surgeons. The material presented in the Closure Course is unique and will nicely complement the topics and activities offered in Dermatologic Surgery: Focus on Skin Cancer (see below).

May 22-25, 2014 - Dermatologic Surgery: Focus on Skin Cancer
Top experts in Cutaneous Oncology, Dermatologic Surgery and Dermatopathology will provide updates on a wide range of surgical and Mohs topics. Interactive forum and panel participants will discuss appropriate repair strategies for different types of surgical wounds as well as innovative approaches to melanoma treatment and a variety of medicolegal controversies in dermatologic surgery. Both Mohs and non-Mohs histopathology cases provided by leading dermatopathologists will be featured in the microscope laboratory. Mohs technicians and nursing personnel are welcome to attend these sessions to further their understanding of skin cancer treatment and enhance their contributions to quality patient care and surgical efficiency.

Fundamentals of Mohs Pathology and Fundamentals of Mohs Surgery

DoubleTree Hotel San Diego, Mission Valley – San Diego, California

November 4-5, 2014 – Fundamentals of Mohs Pathology
This course will be a practical “pure pathology” experience for physicians who are interested in understanding all the subtle characteristics of basal cell and squamous cell carcinoma, the most common tumors treated with Mohs surgery. Fundamentals of Mohs Pathology will prepare attendees to accurately read and interpret BCC and SCC in all its variations, as well as learn to differentiate BCC and SCC from background findings that physicians will encounter in viewing their own future Mohs slides. This material will complement the material covered in the Fundamentals of Mohs Surgery course (see below), and participants will be able to readily apply the knowledge gained to their review of hundreds of Mohs cases during the Fundamentals of Mohs Surgery course.

November 6-9, 2014 – Fundamentals of Mohs Surgery
Physicians will be able to build upon and improve their skills in Mohs surgery and related histopathologic interpretation. Experienced Mohs surgeons on faculty will share their intimate knowledge of the technique with new dermatologists and others who wish to incorporate this technique into their practices. The course also includes valuable information regarding Mohs practice set-up, CLIA-OSHA requirements, billing and coding, and other practice administration tips. Video microscope small group sessions, along with ample time for individual review of Mohs cases, will reinforce the Mohs histopathology topics covered in lectures. A separate Mohs technician course will run concurrently with the physician program, with individual instruction in tissue processing as well as other laboratory requirements and safety concerns. The surgeon-technician “team approach” to Mohs surgery will be emphasized.

For additional information regarding ASMS educational activities, membership opportunities, and patient resources, please contact:

Novella Rodgers, Executive Director
American Society for Mohs Surgery
5901 Warner Avenue, Box 391
Huntington Beach, CA 92649-4659
Tel: 800-616-2767 or 714-379-6262
Fax: 714-379-6272
www.mohssurgery.org
execdir@mohssurgery.org
When I took office as your president I knew it could be a tough year with lots of changes facing our specialty. I also knew I would be working with a great team. As it turns out, I was right on both counts. Never before has our specialty faced such fundamental changes in how health care is delivered. The rapidly changing landscape of regulation, reimbursement, and limited provider networks is complex and difficult to navigate, but the AAD will always be there to provide tools and guidance to help each of us to continue to practice and thrive in a changing environment.

With the help of a broadly representative group of leaders from our state and local societies, we established a set of key priorities fundamental to the future of our specialty. They included establishing how dermatologists fit into new payment and care delivery models, developing plans to obtain the data we need to demonstrate the value dermatologists bring to patient care and the health care system, enhancing the image of our specialty, and optimizing our support of state and local dermatology societies as they confront a growing range of issues. Our state societies are our specialty’s front line, and the AAD has established an ad hoc task force under the leadership of Mary Maloney to improve coordination on issues as they arise locally. A bad payer policy that dermatologists confront in one state will rarely remain regional. Each regional challenge is one that can potentially affect us in many states. Most state societies have limited resources to fight these battles, and the AAD is there to provide expertise and staff support to mount coordinated efforts on issues that can affect us all.

A productive health policy strategic retreat, held late last spring, brought together thought leaders to discuss critical areas that needed to be addressed to ensure future success for the specialty. We also did some hard work on the perception of the specialty. An ad hoc task force is working on a variety of recommendations to help improve the way we are perceived by our medical colleagues, especially in primary care as our nation rolls out new health care delivery systems based on the patient-centered medical home model. The Government Accountability Office’s report on dermatopathology showed us just how tough the environment is for us right now. The study suggested that on average, dermatologists who in-source dermatopathology demonstrate a sharp increase in the number of biopsies per patient — several groups seized on the findings to call for closing the Stark Law exceptions that allow dermatologists to use the full scope of our training to read slides for our patients. What is at stake is no less than our scope of practice, as our right to read slides is key to the practice of Mohs surgery as well as dermatopathology.

Over the past year, we have responded successfully to each of these challenges, and I know that as I hand the reins to Dr. Coldiron, the Academy will continue to move forward on these issues and new ones that will arise.

In the face of these challenges, we need to remember what is good. We are privileged to practice a specialty that can provide its patients with dramatic improvements in their health and quality of life. We give back in so many ways. As a group, we turned Niagara Falls orange on Melanoma Monday to raise skin cancer awareness and made possible the continued success of Camp Discovery. Every time one of us works to squeeze in a patient who cannot pay at the end of a long day, to see a hospital consult, or to volunteer in the community we enhance the image of our specialty and reinforce why we chose to go into the most noble of professions.

To face the challenges ahead, we must stick together. Dermatology is a small specialty, representing less than 2 percent of physicians, but we have always been successful in projecting a voice much larger than our numbers. Unity is key to our success. There are many ways to fail as we move forward. My year as president has convinced me that there is only one way to succeed: we must work together with a unified vision of ourselves as dermatologists and the Academy as our unified voice. Our future is in good hands with Brett at the helm and a dedicated team at his side. It has been an honor to serve as your president and I leave knowing that our leadership team is strong and the future is bright. dw
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Adapting the Academy

BY ELAINE WEISS, JD

THIS MONTH’S DERMATOLOGY WORLD focuses on the future of the profession. It addresses critical questions: What will your practices look like? How will you be reimbursed? What treatments will you use?

The Academy is addressing critical questions about its future, too. How do we stay true to our mission while adapting to changing technology, regulations, and expectations? As the profession changes, what changes does the Academy have to make to continue to serve the needs of its members?

It’s clear to me that in an age when everything is virtual — including, as described in one of this month’s articles, some patient visits — and residents are trained with smartphones in their hands and access journals on their tablets, the way we deliver education and communicate with members has to adapt. We need to integrate our grassroots members into our D.C. and state-level advocacy efforts in a nimble way that ensures they can be involved in a timely manner when an important issue suddenly heats up. We need an organization that is flexible enough to meet member needs in a rapidly changing environment — without diminishing our ability to deliver the vital resources members and the public expect at the same level of quality. This flexibility is not always a strength of associations. But we have a superb and dedicated staff that can deliver.

For example, staff are currently working on a new Learning Management System, a state-of-the-art “online educational home.” This is a significant technology investment that will provide members with a personalized dashboard, an eLearning portfolio, and the ability to track your participation in the kinds of continuing medical education activities that you need to meet updated requirements.

The organization has also made great strides in the last decade in developing evidence-based guidelines and appropriate use criteria. But we recognize that it is not enough to publish a paper in a journal anymore; we need to make the information useful to members in their daily practice. Apps based on our psoriasis guidelines and our Mohs surgery AUC do just that; visit www.aad.org/mobile-psoriasis and www.aad.org/mohsaucc to learn more.

And while our Annual Meeting is the premier source of dermatology-focused CME, we know that it isn’t enough to publish a book that lists all of the courses; today we give members the option of downloading an app to check out session information as they move through the Annual Meeting, review maps of the convention center, and interact with one another. Click on “Meeting mobile app” at www.aad.org/meetings/2014-annual-meeting to get the app.

Meanwhile, webinars give members and their staffs an opportunity to hear directly from Academy staff experts about the latest regulatory changes and how practices can handle them. Visit www.aad.org/webinars to find out about the next one or to download previous webinars.

We know that more changes will be necessary as time goes on so we can continue to meet your needs. We’re evolving with the profession. We’re not only identifying the important issues on the horizon (as we do in this edition of Dermatology World) but also making sure the AAD changes how it does business on behalf of members to keep pace with the changing environment.

CAMP DISCOVERY, the Academy’s summer camp program for children with chronic skin conditions, is a unique experience for children who may otherwise miss out on participating in such an event. Patients between the ages of 8-16 can be referred to one of the following six weeks of camp:

• Camp Little Pine, Crosslake, Minn., for ages 10-14, June 22-27
• Camp Reflection, Carnation, Wash., for ages 8-16, June 23-27
• Camp Big Trout, Crosslake, Minn., for ages 14-16, July 6-11
• Camp Dermadillo, Burton, Texas, for ages 9-15, Aug. 10-15
• Camp Horizon, Millville, Pa., for ages 8-13, Aug. 9-15
• Camp Liberty, Andover, Conn., for ages 8-16, Aug. 10-16

VOLUNTEER YOUR TIME AT CAMP DISCOVERY

While camp is an experience like no other for the children who attend, it can also offer a distinctive experience to the physicians who volunteer. Volunteer applications are currently being accepted. Contact Janine Mueller at (847) 240-1737 or jmueller@aad.org or visit the Camp Discovery website, www.campdiscovery.org, to complete an application online.

SUPPORT THE CAMP DISCOVERY ENDOWMENT

Academy members can also support Camp Discovery by making donations to the Camp Discovery Endowment Fund. For information on making a contribution to this valuable Academy program, contact Valerie Thompson at (847) 240-1427 or vthompson@aad.org. – JANINE MUELLER

www.aad.org/dw
Meet the 2014 Academy election candidates

MEMBERS CAN VIEW the candidates’ background materials, the ballot book, and the proposed dues increase at www.aad.org/aadelection. The president-elect speeches for the Annual Business Meeting and videotaped candidate statements will also be posted to the election site by March 25.

NEW CANDIDATE TOWN HALL QUESTION AND ANSWER FORUM

The Candidate Town Hall Question and Answer Forum, accessible at www.aad.org/aadelection, provides candidates the opportunity to respond to member questions. Beginning Feb. 26, members may submit questions by email to candidates@aad.org. All questions will be reviewed by the chair of the Ad Hoc Task Force on Election Oversight (AHTF). Should a question be considered duplicative, inflammatory, offensive, or otherwise inappropriate in nature, it will be forwarded to the AHTF for evaluation. The AHTF has the authority to refuse to post or to consolidate such questions. Candidates will be under no obligation to respond to posted questions. The questions and responses will be available at www.aad.org/townhall for membership viewing until the election closes on April 21. (Refer to the Excerpt of the Administrative Regulation on Nomination and Election Procedures 13. h.)

VOTING OPENS MARCH 22

The 2014 Academy Election opens on March 22 at 12:01 a.m. (EDT). Members can access the Academy election site at www.aad.org/aadelection or use the direct link at https://www.esc-vote.com/aad2014 to vote. Election Services Corporation (ESC) will send access codes to all eligible voting members on March 3 via email or mail (for those without email addresses). When voting, use your secure access code and AAD member identification number. ESC will continue to provide access codes via email each week through April 21.

If you require assistance with your secure access code during the Annual Meeting on Saturday, March 22 or Sunday, March 23, please contact ESC between 9 a.m. and 5 p.m. (MDT) at their toll free number, (866) 720-4357 or via email at aadhelp@electionservicescorp.com.

VOTING DEADLINE IS APRIL 21

Paper and online voting concludes on Monday, April 21. Ballots must be received or electronically posted on April 21 by 11:59 p.m. (EDT).

Alan Shalita, MD, former AAD vice president, mourned

ALAN R. SHALITA, MD, who served as AAD vice president in 1995, died on Feb. 2. He was 77 years old.

Dr. Shalita completed his medical degree at the Bowman Grey School of Medicine of Wake Forest University. He completed his dermatology residency at New York University Medical Center in 1970. From 1975 onward he served as chief of dermatology at the University Hospital of Brooklyn and Kings County Hospital Center. He was also the chair of the department of dermatology at SUNY Downstate Medical Center.

In addition to serving as vice president of the AAD, Dr. Shalita served as president of the American Dermatological Association and the Association of Professors of Dermatology. He also served as deputy secretary general of the World Congress of Dermatology. Dr. Shalita was named an Honorary Member of the Academy in 2008. In 2013 he received the organization’s highest honor, the Gold Medal. – RICHARD NELSON
Obituaries

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


Anthony P. Cipriano, MD, 96, Branford, Conn. Completed dermatology residency training at Yale University School of Medicine. Died May 27, 2012.


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.

Annual Business Meeting agenda

THE AMERICAN ACADEMY OF DERMATOLOGY’s Annual Business Meeting will be held on March 23, 2014 in Belco Theatre in the Colorado Convention Center at 8 a.m. It will follow the agenda below:

**8:00 A.M. BUSINESS & BAGELS**

AMERICAN ACADEMY OF DERMATOLOGY (AAD) BUSINESS MEETING

I. Call Assembly to Order
II. Establish Quorum
III. Introductions and Acknowledgements
IV. President-Elect Candidates’ Statements
V. Recognition of Industry
VI. Awards Acknowledgements
VII. Secretary-Treasurer’s Report
VIII. Unfinished Business
IX. New Business
X. Announcements
XI. Adjournment

AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION (AADA) BUSINESS MEETING

I. Call Assembly to Order
II. Establish Quorum
III. Secretary-Treasurer’s Report
IV. Unfinished Business
V. New Business
VI. Recognition of Retiring Board Officers
VII. Adjournment

INFORMAL DISCUSSION OF ISSUES OF IMPORTANCE FROM THE FLOOR*

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

*No CME Credit.
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<th>Title</th>
<th>Authors</th>
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<td>Illustrated Guide to Chemical Peels: Basics, Indications, Uses</td>
<td>Mark G. Rubin et al</td>
<td>Outlines the steps for providing optimal chemical peels—whether superficial, medium, or deep—that are individually tailored and take into consideration the skin quality of each patient.</td>
<td>204</td>
<td>306 illus.</td>
<td>ISBN 978-1-85097-252-5 (D2525)</td>
<td>US $178</td>
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In recognition of her volunteer work on behalf of the Academy’s educational initiatives, University of Utah dermatology resident Sarah Cipriano, MD, MPH, MS, will be awarded the first Rising Star in Education Award. The award is presented to a medical student, dermatology resident, or fellow recognized for exceptional contributions to Academy educational programs.

Dr. Cipriano has been working with Academy programs since 2010, and oversaw online content creation for the Medical Student Core Curriculum. She coordinated assignments, reviewed submissions, and coordinated with Academy staff to incorporate the content into AAD.org. The project, which required more than 1,500 hours of Dr. Cipriano’s time, benefits medical students throughout the world, and is continually updated and maintained with her involvement. The results are available at www.aad.org/mscc.

Currently, she has been working on a sustainable ethics curriculum at the University of Utah that includes a biannual ethics forum including case-based discussions between dermatology residents and faculty. She is also working on a study that examines the perception of black salve use among her patient population in order to create an educational campaign about the importance of seeking care prior to self-treating lesions.

“When people who have been helped by these mentorship programs come back and speak with me, it urges me to work harder.”

- JOHN CARRUTHERS

NEW DELHI DERMATOLOGIST Rashmi Sarkar, MD, realized years ago that building a stronger specialty in India required stronger mentorship programs and more interaction with international colleagues. Not one to leave the work to others, she became heavily involved in the international arm of the Women’s Dermatologic Society (WDS), became the founding editor of the Asian Pigment Bulletin, and brought young dermatologists into the fold in multiple international societies and publications. In the meantime, she still managed to continue seeing patients, supervise research, and volunteer at a camp for orphan girls in her hometown.

“Dr. Sarkar became interested in volunteering within the specialty when she received a WDS travel grant to the Academy’s 64th Annual Meeting in 2006.

“Attending the lectures and the WDS luncheon made me aware of the importance of fostering mentorships and friendships among women dermatologists globally,” Dr. Sarkar said. “It made me want to be a part of the process.”

As part of her volunteer membership work with the WDS, Dr. Sarkar has increased the society’s membership rate in her country by 100 percent. She is also serving as the 2014-2015 national secretary of the Indian Association of Dermatologists, Venereologists, and Leprologists.

“I am dedicated to helping fellow dermatologists in their professional growth and in expanding opportunities in India for colleagues to connect, support one another, exchange ideas, and advance dermatology overall,” she said. She mentors younger dermatologists, helping them find opportunities to participate, earn scholarships, and have their manuscripts published.

“Volunteering my time excites me. It helps in building international liaisons for research and mentoring, which works well for me and the young dermatologists in India.”

- JOHN CARRUTHERS
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**Wonderful Dermatology opportunity in Central Florida for BC/BE Dermatologist**

Central Florida Dermatology and Skin Cancer Center (CFD) is seeking a BC/BE 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 BC/C Dermatologist, and four mid-level extenders. We have an in-house 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 ext. 7, or email CV to Daniel@CentralFlDermatology.com. Visit us on the web at [www.centralfldermatology.com](http://www.centralfldermatology.com)

**Central Florida Dermatology**

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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) 665-3553, Fax (617) 665-3553 or via e-mail: lschofield@challiance.org, EDE: [www.challiance.org](http://www.challiance.org)

**From Practice to Play NOW THIS IS LIVING**

**The University Hospital** of Northern BC (UHNBC), Prince George, British Columbia, Canada is actively recruiting to replace our current dermatologist who is retiring. This person will provide full-time services to a region of approximately 80,000 people as well as referrals from outlying communities (total population approx. 400,000). Northern Health will assist in locating suitable office space. Augment your clinical practice with teaching opportunities through the UBC Northern Medical Program in Prince George, as part of the faculty with the UBC Department of Dermatology and Skin Science.

Join the robust Department of Internal Medicine, comprised of 20 members with specialty interests in Cardiology, Gastroenterology, Nephrology, Infectious Diseases, Respiratory, Neurology, Rheumatology, and Endocrinology. Adjacent to the hospital, the new BC Cancer Centre provides residents of northern BC with increased access to cancer treatment and services closer to home.

Located in north-central BC, Prince George is a city with a range of cultural, educational and recreational amenities and some of the most affordable, high-quality housing in the West. The lakes, forests and mountains of northern and central BC offer an unparalleled natural environment in which to live and work. For more information about living and working in Prince George please email physicians@northernhealth.ca or telephone 250-649-7117.
PROFESSIONAL OPPORTUNITIES

Manchester, New Hampshire

We are seeking a full or part-time Dermatologist/Mohs Surgeon to join our group of twelve board certified dermatologists in a professionally run practice with dermatopathology lab, Mohs surgery, and medical aesthetics. This opportunity would allow a highly qualified Dermatologist/Mohs Surgeon to practice with excellent support staff in a collegial practice in our Manchester or Wolfeboro New Hampshire offices with competitive salary, benefits and opportunity for practice ownership. For more information, please contact: Glenn Smith, MHA, Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

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PORTERVILLE, CALIFORNIA

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Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

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Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

GROTON, CONNECTICUT

Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

RENO, NEVADA

Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

ORLANDO, FLORIDA

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Baltimore Suburbs

Skin Care Specialty Physicians is offering a competitive and desirable FT/PT opportunity for a BC/BE Dermatologist. Join 3 physicians in a busy and well-established private practice in Lutherville, Maryland. We offer flexible work hours and. Competitive and Performance - Based Pay, Health and malpractice insurance, paid time off for vacations and CME, 401K profit sharing eligible after two years of employment. If interested please contact Mary Ann Hand at Skin Care Specialty at (410) 252-9090 or email mhand@scsphysicians.com for questions and/or a complete job package.

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

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Phone: (847) 240-1770
Email: cparratt@aad.org
Website: www.aad.org/dw

SALES INFORMATION

UPCOMING DEADLINES FOR 2014 ISSUES:

May.......................... March 28
June..........................April 25
July..........................May 30
Here’s to the next 20 years!

The SDPA will celebrate our 20th Anniversary in 2014. We want to thank you, our supervising physicians, for your mentorship, teaching and collaboration. We and our patients reap the benefits of the teamwork developed over this time.

We also want to thank the Academy for making access to the PQRS reporting registry available to nonphysician providers. It is further evidence that the Academy and your members are embracing the team concept for which physician assistants were trained.

During our Summer 2014 meeting in Indianapolis, in addition to world class speakers, we will be having a 20th Anniversary Gala. We hope you will recommend that your PA or NP attend to hear great speakers, attend workshops and celebrate our first 20 years. Here’s looking forward to the next 20 years.

www.dermpa.org | 1-800-380-3922
As dermatologists grapple with the right way to integrate non-physician clinicians into their practices to enable them to provide care for a growing patient population, three recent studies indicate that such providers will make up an increasing proportion of the medical workforce in the future. (For further discussion of how non-physicians clinicians may play a role in dermatology’s future, see “The future of dermatology practices article beginning on p. 26.)

The first, “The Complexities of Physician Supply and Demand: Projections Through 2025,” was conducted in November 2008 by the American Association of Medical Colleges. It found that the supply of full-time equivalent physicians would grow from 680,500 in 2005 to 734,900 in 2025 without any changes in policy. The second, “Predictive Modeling the Physician Assistant Supply: 2010–2025,” appeared in the September-October 2011 issue of Public Health Reports. It projected growth in the number of physician assistants (PAs) from 74,476 in 2010 to 127,821 in 2025. The third, “Growth of the Nurse Practitioner Workforce,” appeared in Medical Care on Feb. 17, 2012. It projected that the number of nurse practitioners would rise from 86,000 in 2008 to 198,000 in 2025.

The chart below compares these rates of increase. – RICHARD NELSON, CMPP

Workforce growth in medicine overall by 2025
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