A Matter of PERCEPTION

How dermatologists are viewed by other physicians — and what they can do about it
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DEAR READERS,

The “lightning bolt” moment... we’ve all had one.

I have enabled me to take many a bold step both personally and in my work life. For example, when my kids were little I had one of those “ah-ha!” moments where I just knew that I wanted to work less than full time. I knew right then and there that I would find a way to make it work while still remaining very devoted to my career. It was not an easy course to plan in those days, but with the clarity of vision that that kind of thinking provides, plans can truly leap forward. Fourteen years ago I had another one of those moments when I decided to leave my practice and head back to academia at Penn. Got many a confused look, but inner clarity prevailed, and I’ve been the happier for it. However, I don’t know about you, but I have a lot of thoughts that circle in my head, and the trickiest part is knowing which ones are going to be visionary. Ideas which seem at first quite profound often dissipate after a few days. I instinctively don’t trust any thoughts I might have while stuck in traffic or waiting for a very early train to get to my office. They might lead me to forego many an event or quit my job! The surgeons among us might disagree — they may always trust that inner voice, so this confusion may reflect more about me than anything more. But whether we all are certain immediately or it takes a little time, I think we’ve all had those occasions where clarity serves us well and guides our paths. As I read over our articles for you this month it occurs to me that some of you may find our pieces triggering those eureka moments.

Our feature this month on moving a practice got me thinking about “lightbulb” moments. Who among us has not thought about this — either because our space was growing too small, our referral patterns were changing, or personal priorities beckoned? We at DW thought it would be of great interest to talk to people who made the decision to move forward with these plans, so that you don’t have to re-invent the wheel. Remembering to make all of the needed arrangements is certainly key to any such plan. While of course each situation is unique, there is much that can be learned from others who have recently successfully accomplished the task. Remember you can always search “moving a practice” at www.aad.org/dw when it becomes applicable to you. Guess we’ll all need it sometime unless they cart you out of your office in a box.

Lightning moments can also trigger us to do negative things...such as giving up the practice of dermatology. Hopefully Rachna Chaudhari’s guidance on audits will help each of us let that thought go. She understands why we are all feeling somewhat abused given the possibility of RAC audits, HIPAA audits, and now meaningful use audits. It’s enough to make all of us become libertarians! Be sure to read her piece; her advice for handling these meddlesome events will be helpful.

Similarly, Morris Stemp’s piece on health information exchanges (HIEs) will help you navigate our next governmental hassle — the meaningful use stage 2 requirements. They are set for implementation January 2014, although some are lobbying to have this delayed. Eventually it will come, so read on. Stemp helps us better understand what these HIEs are, how they will work, and what is involved in participating in them. Hopefully being informed will keep us all from quitting en masse.

Lots to read and hopefully much to aid you in guiding your practices. Eureka was first shouted by Archimedes when he figured out how to measure the mass of gold, which led to him running through the streets of Syracuse. We’d love to see some video footage of any of you running through your local streets when you’ve had your clarifying moments too — promise we’ll put that on the DW website.

Enjoy your reading!

ABBY S. VAN VOORHEES, MD, PHYSICIAN EDITOR
“If we as dermatologists are going to have the opportunity to be a part of some of these new medical care practices, it will be important for us to have a good reputation and respect within our community.”

COVER STORY
A MATTER OF PERCEPTION
How dermatologists are viewed by other physicians — and what they can do about it
BY JAN BOWERS

MOVING UP, MOVING OUT
Dermatologists detail the moving process, from cross-town to cross-country
BY JOHN CARRUTHERS

DERMATOLOGISTS ON THE FRONT LINE IN DETECTING VENOUS DISEASE
BY DIANE DONOFRIO ANGELUCCI
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BY ALEXANDER MILLER, MD

When modifier 59 is not enough

CODING CORRECTLY FOR COVERED SERVICES, AVOIDING BILLING FOR EXCLUDED SERVICES

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.

A Medicare patient visits you for the second time in the calendar year, this time with complaints of growing, occasionally bleeding facial lesions. You identify scattered keratotic actinic keratoses (AKs) as well as probable basal cell carcinomas located on the cheek and nose. You destroy five AKs with liquid nitrogen and biopsy both suspected basal cell carcinomas. Your office then bills for two biopsies, CPT codes 11100 and 11101, and for the actinic keratoses destruction, CPT code 17000-59 and 17003-59x4.

Will you be reimbursed appropriately for your efforts?

There are several steps that must be considered in order to determine whether any procedures are reimbursable, and if yes, then how coding should be done to generate appropriate recognition of and payment for your work:

1. Is what is done a covered service or is it excluded from reimbursement?
2. Are the codes, when paired (billed on the same encounter), all payable?
3. If the codes are in principle payable, then which code should be the primary code, and which should receive a modifier?
4. Which modifier(s) should be used?

Knowing what is a covered service can help avoid the frustration of billing an insurer for a service and receiving a denial of payment. Private insurers vary in their coverage policies. Medicare, however, clearly divulges coverage criteria. The September 2011 Medicare Learning Network transmittal, titled “Items and Services That Are Not Covered Under the Medicare Program” (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Items_and_Services_Not_Covered_Under_Medicare_BookletICN906765.pdf), specifies that cosmetic surgery, which is “…any surgical procedure directed at improving the beneficiary’s appearance,” is not covered. Coverage may be further detailed in a National Coverage Determination (NCD) and in your local Medicare contractor’s Local Coverage Determinations (LCDs). Although dermatology-specific NCDs are few, there is one for actinic keratoses (NCD 250.4), which states that they are covered “without restrictions based on patient or lesion characteristics.” However, the NCD guidelines also allow the local Medicare contractors to independently determine maximum number of treatment visits. Consequently, one should be familiar with any pertinent local contractor’s LCDs, and if none is available, then with the contractor’s coverage and payment patterns.

Some Medicare contractors have generated LCDs specifying treatment frequency coverage limits for actinic keratoses and/or coverage criteria for benign lesion removals. The LCDs are readily accessible on your Medicare contractor’s website. An actinic keratosis LCD will list secondary diagnoses that, when present and billed, exclude AK treatments from the visit frequency limits. In such cases, one would link the 17000-17004 destruction codes with the ICD-9-CM for actinic keratosis as the primary code (702.0) and a second code justifying the visit frequency. This secondary code may, for example, specify immunosuppression or a history of skin cancer, or any other pertinent qualifying diagnosis listed in the LCD. The billing staff needs to know this in order to code properly and for you to be paid. The physician has to know this in order to provide the appropriate supporting medical records and billing information.

Consider that Medicare expects you to know what services are never covered, which services may have a frequency of visits limitation of coverage, and which are reasonable and necessary. If in doubt about Medicare coverage of a service, or if you suspect that the service may exceed the maximum treatment visits per year limitation, then fill out and have the patient complete and sign an Advanced
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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.
Beneficiary Notice (ABN), available on the websites of both your Medicare contractor and CMS. Guidance on what is covered and not covered, and specifics about the ABN, appear in the May 2012 MLN article titled, “Advance Beneficiary Notice of Noncoverage” (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf). Significant for everyone’s billing practices is the following quote from the publication: “Medicare expects you to know both current NCDs and LCDs” (bold lettering from the original). When is an ABN not needed? It is when services are known to be covered and when they are known to be statutorily not covered.

There are four different modifiers related to ABN use and/or potential non-coverage of a service by Medicare. These are appended to individual CPT codes billed to Medicare.

- **GA**: Indicates that a given charge may or may not be covered by Medicare, and that an ABN has been obtained and is on file.
- **GX**: Indicates that a service is not covered because it is statutorily excluded from coverage or is not a Medicare benefit but an ABN has been obtained as a voluntary option.
- **GY**: Indicates that the service provided is statutorily excluded from coverage. (Note that in such a case one is not required to submit any bill to Medicare).
- **GZ**: Indicates that a charge is not likely to be covered due to a lack of medical necessity, and no ABN was obtained. (In the case of payment denial due to lack of medical necessity the patient would not be liable for the bill because an ABN was not obtained).

Now, let’s return to the clinical vignette at the top of this article. As this is only the patient’s second visit in the calendar year, treatment frequency limitations will not apply to actinic keratoses destruction, and CPT codes 17000 and 17003x4 should be covered. As basal cell carcinomas are clinically suspected, biopsies, CPT 11000 and 11101, are done for medically necessary reasons and should also be covered. However, will the use and placement of modifier 59 described at the beginning of this article provide for reimbursement? Find out in next month’s continuation article.

**Example 1**: A Medicare patient with a raised, dark, stable nevus of several decades’ duration would like it removed because it grows an annoying thick, long, and dark hair. You tell the patient that the mole can be excised, and that it is considered a cosmetic-non-reimbursable lesion. The patient insists that you excise it but also wants you to bill Medicare to prove that it is not covered. You agree, excise the mole, and bill Medicare for the excision.

**Answer: Incorrect.** As the excision is for enhancement of appearance, it is considered a non-covered, cosmetic procedure. Whambo! Medicare will not pay, with an explanation that the patient is not responsible for payment. You get nothing. What went wrong? The claim should have been submitted with a –GY modifier stipulating that the service is statutorily excluded from Medicare benefits. As the service is never covered, you were not required to obtain a signed ABN form. However, such a form helps to document non-coverage. When an ABN is obtained, the service may be billed with a –GX modifier in addition to the –GY, indicating that a voluntary ABN has been obtained.

**Example 2**: You excise a Medicare patient’s previously stable but now suddenly tender, red, and bulging epidermoid cyst located on the back. You bill for the excision along with ICD-9 diagnoses 706.2 for the cyst and 682.2 for the abscess.

**Answer: Correct.** Medicare and, typically, other insurers will cover treatment of an abscessed or inflamed epidermoid cyst. As this is a covered service, no ABN is needed. In the billing sequence, the epidermoid cyst diagnosis should be primary, and the abscess, secondary.

**Example 3**: A patient with a past history of skin cancers visits your California office for the seventh time in the past 12 months for destruction of actinic keratoses. You freeze eight actinic keratoses and bill Medicare with CPT 17000 and CPT 17003x7 along with an ICD-9 diagnosis code 702.0.

**Answer: Incorrect.** The Medicare Administrative Contractor for Jurisdiction E, which includes California, Nevada, Hawaii and Pacific Islands, maintains an Actinic Keratosis LCD that specifically limits coverage for AK destruction to six visits per 12-month period. A visit frequency beyond this limit may be justified by coding for any of a variety of qualifying criteria, including immunocompromise, extreme sun damage, prior therapeutic radiation or cancer causing drug exposure, predisposing conditions such as albinism, and personal history of skin cancer. In this example the patient’s treatment would be made eligible for reimbursement by billing with the primary AK ICD-9 diagnosis 702.0 plus a secondary code, V10.83, “personal history of skin cancer.” dw
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Exchanges on the forefront of state medical news

STATE NEWS ROUNDUP

HEALTH INSURANCE EXCHANGES

HEALTH insurance exchanges, the centerpiece of the 2010 Affordable Care Act, are set to become certified and operational at the start of 2014. Open enrollment begins Oct. 1, 2013. The marketplaces, which allow individuals and small businesses to compare policies before purchasing health insurance, are handled under three models. Most states had chosen which model they would pursue at press time.

STATE EXCHANGES

These states plan to run their own exchanges.
- California passed the first exchange legislation in the country under then-Gov. Arnold Schwarzenegger. An exchange board was created in 2011 and the state has received $40 million in grants through the U.S. Department of Health and Human Services.
- Connecticut passed state exchange legislation in 2011. The state exchange has a board in place but is still searching for a CEO.
- The District of Columbia has also elected to run its own exchange. The city plans to be an active purchaser of insurance plans, consolidating the city's smaller group and individual markets into the exchange.
- Hawaii, which has had an employer mandate in place for almost four decades, created the Hawaii Health Connector in 2011. The board is currently working to consolidate the state-run exchange with the existing employer mandate and delineate the responsibilities of employers under the new federal regulations.
- Idaho's governor signed the bill creating a state exchange in March 2013, just months before the open enrollment date.
- Maryland passed legislation in 2012 that required most insurers to offer plans on the exchange in order to sell other insurance products in the state.
- Massachusetts, in many ways the model for the current systemic overhaul, already has a state exchange that is in the process of fine-tuning to become federally certified.
- Minnesota's exchange was the result of a 2011 executive order, and Democratic majorities in both houses passed legislation in support of it in 2013.
- Rhode Island has funded its exchange through 2014 as a result of receiving the nation's first Level Two grant — resulting in $128 million in exchange funding — in May 2013.
- Vermont, in addition to 2011 health exchange legislation, passed a bill in 2012 that required individuals and businesses with fewer than 50 workers to purchase coverage through the exchange.
- Washington became just the second state to obtain a Level Two grant — resulting in $128 million in exchange funding — in May 2013.
- Also participating in state-run exchanges: Colorado, Kentucky, Nevada, New Mexico, New York, and Oregon.

FEDERAL EXCHANGES

The lawmakers in a number of states have decided to leave the construction and operation of insurance exchanges to the federal government.
- Alabama Gov. Robert Bentley, MD, originally expressed support of a state-run exchange, going so far as to appoint an executive director. But after examining costs, Dr. Bentley decided on a federal
Two widely read salary surveys show slight growth in dermatology compensation in 2012

SURVEYS OF DERMATOLOGY COMPENSATION offer dermatologists data they can use to benchmark their practices — and often create the foundation for outside impressions of the specialty. According to two of the best-known and widely reported compensation surveys, dermatology compensation increased slightly in 2012.

The median compensation for dermatologists grew by 5.55 percent in 2012 according to the Medical Group Management Association’s (MGMA’s) 2013 Physician Compensation and Production Survey, based on 2012 data. The survey’s top-line data showed median compensation for dermatologists rose from $446,774 in 2011 to $471,555 in 2012. Specialists in general saw a 3.06 percent increase in median compensation in 2012, according to MGMA. The figures for dermatology reported in the MGMA survey are based on responses from 298 dermatologists, including 38 who defined themselves as Mohs surgeons and 12 who defined themselves as dermatopathologists. Data without Mohs or dermatopathology, reported as the median for dermatology in some outlets, showed a compensation figure of $446,061.

The American Medical Group Association’s (AMGA’s) 2013 Medical Group Compensation and Financial Survey, based on 2012 data, showed a 3.56 percent increase in median compensation for dermatologists, from $397,370 in 2011 to $411,499. The AMGA figures for dermatology are based on responses from 87 Mohs surgeons with a median compensation of $595,800.

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Sources: 2013 MGMA Physician Compensation and Production Survey, AMGA 2013 Medical Group Compensation and Financial Survey

- JOHN CARRUTHERS
Can universal decolonization reduce MRSA infections?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Susan S. Huang, MD, MPH about her recent New England Journal of Medicine article, “Targeted versus Universal Decolonization to Prevent ICU Infection.”

Q&A

DR. VAN VOORHEES: How much of a problem are methicillin-resistant Staphylococcus aureus (MRSA) infections in the hospital setting? What kinds of infections are these patients at increased risk for?

DR. HUANG: MRSA is still producing substantial problems, both from cases that are acquired in the community and come into the hospital setting and from hospital-associated infections. Even though the nation has made great strides in reducing hospital-associated infections, the CDC’s most recent data, from January of this year, suggest that Staph aureus, as the combination of MRSA and MSSA, is still the number one health care-associated infection pathogen. Staph aureus is a virulent bacterium which can affect almost all organ systems and is still a major pathogen to be contended with.

The types of infections that come from the community are usually skin and soft-tissue infections, but can also include superimposed pneumonia after influenza, for example. In the hospital, the most common things relate to hospital-acquired pneumonia, bloodstream infections, and skin and wound infections, including surgical-site infections. What’s most important is that the people who acquire MRSA, either as a carrier or those who become infected, usually have a high-risk profile. They usually have serious comorbidities, wounds or other loss of intact skin, or devices which put them at greater risk and they commonly have multiple outpatient or inpatient visits for medical care.

The other thing that I should mention is that MRSA infections that occur in the hospital and the post-discharge setting can be quite serious; in general, about a quarter of them involve the bloodstream.

DR. VAN VOORHEES: Are there patient populations who are considered high risk?

DR. HUANG: The risk factors most commonly noted in the literature are...
diabetes, hemodialysis, wound and skin disorders including eczema or other chronic skin conditions that provide a portal of entry, those who have active cancer or are immunosuppressed, and patients with HIV or AIDS. There are other groups that are also at risk, but those are the most common and persistent risk factors in the literature.

**DR. VAN VOORHEES:** Up until your study how did ICUs typically handle the risk of MRSA infections?

**DR. HUANG:** In general, a hospital’s main arsenal of prevention is to use contact precautions. Many ICUs screen patients upon admission by swabbing their noses for MRSA since the nose is the main reservoir for MRSA. Carriers are then placed into single rooms with gown and glove precautions. This means we are largely focused on preventing spread from someone who already has MRSA, whether it’s an infecting or colonizing pathogen, to someone who doesn’t. I think that’s part of the issue as we look at the U.S. where the prevalence of MRSA continues to rise. Around 8 percent of people who come to the hospital have MRSA; this is a high proportion of people who are carriers, and carriers are predisposed to infection. In recent years, a very strong interest has emerged to do something for the 8-10 percent of hospitalized patients who already have MRSA. That percentage is often even higher in the ICU and in places like nursing homes. If we can get MRSA off the body, off the skin, and out of the noses, we can prevent infection. The strategy, arising in the past decade, is to decolonize using special soaps and nasal ointments to eliminate the carrier state. That’s the thrust of this study and of others that led up to it which enabled us to do a big randomized controlled trial.

**DR. VAN VOORHEES:** What does decolonization of patients entail? Has it been shown to reduce the risk of MRSA acquisition?

**DR. HUANG:** The most common regimen for decolonizing a patient with MRSA consists of five to seven days of daily bathing or showering with chlorhexidine, which is an OTC antiseptic combined with twice daily prescription mupirocin ointment to the front of both nostrils for five days. This regimen has been demonstrated to be effective in removing MRSA from the body and preventing MRSA infections. In the REDUCE MRSA Trial, it has been shown to effectively reduce MRSA burden and all-cause bloodstream infection. Other studies have found a benefit in reducing all-cause bloodstream infections with chlorhexidine alone, but there are data to suggest that it may not be as effective for MRSA as the combination with mupirocin since the nose is the primary reservoir of MRSA.

**DR. VAN VOORHEES:** Tell us about your study. What did you find?

**DR. HUANG:** Our study was a three-arm, cluster-randomized trial; we randomized the hospitals, not individual people. Each participating hospital was assigned a specific campaign and all of the adult ICUs in that hospital did the same thing. The first arm screened the noses of patients who came into the ICU for MRSA. This practice is common in many hospitals and legislated by several states. Those that had a positive screen, a positive clinical culture, or a history of MRSA were placed into contact precautions as is consistent with CDC guidance for hospitals.

The second arm not only screened and isolated patients, but also actively decolonized MRSA carriers with a five-day regimen of mupirocin twice a day and daily no-rinse cloth baths of 2 percent chlorhexidine.

The third arm was the universal decolonization arm. We stopped screening, which saved those costs, and decolonized everyone. Everyone got a five-day regimen of mupirocin twice a day and daily no-rinse cloth baths of 2 percent chlorhexidine for as long as they were in the ICU. If they were only in the ICU three days they got both for three days. If they were in the ICU for three months, the mupirocin stopped after five days and the daily chlorhexidine baths continued.

What we found were two major outcomes. The first was a burden estimate, an estimate of any source of MRSA from a clinical culture that a doctor would send. We chose that as an outcome because since we were decolonizing, we didn’t want to see MRSA from any source, regardless of if it was an infecting strain or just a colonizing strain. We were able to show that the all-cause burden was reduced in the universal decolonization arm by 37 percent. Then we looked at bacteremia. We had two subsets, bacteremia due to MRSA, where we had a nice trend of reduction in the targeted decolonization group but it was not statistically significant — we knew we were underpowered for that outcome. And in the other subset we looked at bloodstream infections from all pathogens and found that the middle arm, the targeted decolonization arm, was better than the routine arm, and the universal arm was better than both with a 44 percent reduction in bloodstream infections.

**DR. VAN VOORHEES:** What costs were associated with the universal decolonization arm?
**DR. HUANG:** In the trial, we used a 2 percent chlorhexidine cloth which currently has a single manufacturer in the U.S. We also used the trade version of mupirocin because it’s FDA-approved to clear MRSA. Nevertheless, hospitals may opt to use generic mupirocin or liquid chlorhexidine in basin baths. For chlorhexidine, the important consideration is whether the application is done properly. This should be possible with a basin bath, but more attention is needed to ensure proper dilution, skin application, and lack of rinsing. Studies are underway to see if skin concentrations following basin baths are similar to the 2 percent no-rinse cloth. If applied correctly by massaging CHG into the skin, it will bind skin proteins and protect against re-colonization of bacteria on the skin for 24 hours. So it works nicely given as a daily bath; you can protect patients every day. Cost will vary depending on the exact product used. Every hospital negotiates its own pricing. Chlorhexidine baths are approximately $6-7 per bath for the cloth, and much less if you use the liquid. It’s worth noting that liquid will lather much better with a mesh sponge. The mupirocin is between $30-40 for the entire five-day course if you use the branded version, or about $5-7 if you use the generic.

**DR. VAN VOORHEES:** As caregivers primarily in the outpatient setting, dermatologists generally utilize mupirocin intranasally for patients with MRSA infections. Are there implications from your work for the patients that we see?

**DR. HUANG:** Yes and no. This particular trial was focused only on ICU patients and whether we were able to effect a change in post-discharge time is unknown. But we have a second trial, Project CLEAR, which is ongoing and is a post-discharge trial. Patients who are discharged with a culture positive for MRSA are randomized to education alone or education plus decolonization for MRSA. Hopefully that will have direct relevance to outpatient settings when results are known in two years.

**DR. HUANG** is associate professor of infectious diseases and medical director, epidemiology and infection prevention at the University of California Irvine School of Medicine. Her article was published in the *New England Journal of Medicine*; N Engl J Med 2013; 368:2255-2265 (June 13). doi: 10.1056/NEJMoa1207290.
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As Bryan is about to leave his law office for the day his receptionist enters his office. She tells him that Madison, a dermatologist and longstanding client, is on the telephone and is quite upset. Bryan answers the telephone.

Bryan: Good afternoon, Madison! How are you?

Madison: Not well. I just finished seeing a patient who has repeatedly failed to comply with my treatment recommendations and is now angry with me because he is not getting better. Furthermore, although he has been told that he needs to make an appointment prior to coming to my office, he shows up repeatedly without having done so. I have discussed this situation with him more than once and it has apparently done no good. I am uncomfortable dealing with him!

Bryan: Rather than struggle with a non-compliant patient whose expectations seem unreasonable, it is in your mutual best interest to dismiss him from your practice. It would seem to be difficult if not impossible for you to fulfill your legal and ethical duties to him if you are not comfortable in your relationship with him, especially if either or both of you have already developed negative feelings toward the other.

Madison: Bryan, I really don’t like dismissing a patient from my practice.

Bryan: Of course you don’t, but it is far better to terminate a bad doctor-patient relationship than to allow problems to escalate. As you have mentioned, the patient is already upset with you.

Madison: What do I need to do to dismiss this patient?

Bryan: You should send him a certified letter, return receipt requested, as well as a copy by regular U.S. mail, letting him know that after 30 days you will no longer be his physician. He should be
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advised to seek further care from another board-certified dermatologist during this time. Furthermore, let him know that you are available to see him by appointment during the next 30 days if he needs to see you. This avoids the accusation that you abandoned him. It is also wise to advise him in the dismissal letter of the medical consequences, if any, of failing to follow-up with another dermatologist.

**Madison:** What if he refuses to accept the certified letter?

**Bryan:** Keep it as part of his medical record. The fact he refused the letter is further evidence of his non-compliance. You do not need to open the letter if it is returned. After all, you know exactly what’s in the envelope since you sent it to him!

**Madison:** Do I have to give a complete explanation for dismissing him?

**Bryan:** No. You do not have to review in explicit detail the events leading to your decision to dismiss him. The intent of a letter dismissing the patient from your practice is not to give him a reason to argue with you, but rather to cleanly and legally terminate the relationship. A general statement indicating that under the present circumstances you do not feel that it is in his best interest for you to continue to provide his medical care is usually sufficient.

You should also be aware that in a few states the Board of Medicine has a form letter available on the Internet that you may use when dismissing a patient.

**Madison:** Should I give him the name of another colleague?

**Bryan:** Absolutely not. It is better to refer him to his primary care physician, the county medical society, a local hospital, or to a similar referral facility. You want to make him responsible for selecting the physician who will subsequently treat him. Besides, do really want to send a patient you are dismissing from your practice to a specific colleague?

**Madison:** Should I enclose a copy of his medical records with the dismissal letter?

**Bryan:** This is usually not required by state law. In my opinion, however, it is wise to do so to eliminate the need for either the patient or a subsequent treating physician to have to contact you to request the same. When you enclose medical records you should indicate in the dismissal letter that you are doing so to facilitate his future medical care.

**Madison:** What should I do if he needs to see me in the next 30 days?

**Bryan:** He should be given an appointment just like any other patient. If he has a true medical emergency you should either attempt to see him immediately or refer him to the emergency room. It is critical, however, that if he comes to your office you do not see him alone. Remember, this is a patient who you are in the process of formally dismissing from your practice. He will most likely not be in a good mood or regard you kindly, to say the least. Having your nurse or another person present at all times you are with him will lessen the likelihood that he will claim you said or did something inappropriate.

**Madison:** What if he makes an appointment and comes to the office or calls to discuss the reason I am dismissing him? What should I do if he apologizes and wants to continue being my patient?

**Bryan:** You do not want to end up debating the patient. You should strive to end the relationship cleanly. Emphasize that your decision to dismiss him is in your mutual best interest and is final. Although I am aware that other attorneys may view this situation differently, I strongly advise you not to accept someone back into your practice once you have sent a dismissal letter. People in this situation are often resentful, hostile, and may even be physically dangerous. If he feels that you have done anything objectionable after you have taken him back into your practice he may not hesitate to complain to the Board of Medicine, make defamatory comments on the Internet concerning you or your practice, or even consider filing a lawsuit against you. After all, you are the one who, from his point of view, had the audacity to dismiss him from your practice. Why would you allow such a situation to occur?

**Madison:** Bryan, I understand and will take your advice. Thank you!

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**KEY POINTS**

1. When dismissing a patient, send a certified letter, return receipt requested, as well as a copy by U.S. mail, advising that you will no longer be providing his or her medical care 30 days after receipt of the letter.

2. Refer the patient to his or her primary care physician, local hospital, or the county medical society to locate another board-certified dermatologist.

3. Although not usually legally required, consider enclosing a copy of the relevant medical records to facilitate the patient’s subsequent medical care.

4. State the consequences, if any, of the patient’s failure to follow-up with another board-certified dermatologist.

5. Should you see the patient within 30 days of his or her receipt of the dismissal letter, have your nurse or someone else present in the room with you to lessen the likelihood that the patient can claim you said or did something inappropriate.

If you have any suggestions for topics to be discussed in this column, please e-mail them to me at loberc@gmail.com. See the February 2013 issue of Dermatology World for disclaimers. dw
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Health information exchanges

HOW THEY WORK, HOW DERMATOLOGISTS CAN CONNECT TO THEM AND START EXCHANGING INFORMATION WITH OTHER PRACTICES/HOSPITALS

One of the key objectives of the government’s push for electronic health records (EHR) and their meaningful use (MU) is to facilitate the easy exchange of patient medical records and health information. How much more effective and less expensive might it be to care for an emergency room patient if the hospital could easily access the patient’s medical records from his primary care provider (PCP) and specialists? Would this sharing enable the hospital to more quickly respond to the patient’s symptoms or perform fewer tests? In an ambulatory setting, could a specialist focus limited appointment time caring for the patient rather than taking a patient history, recording allergies, and duplicating tests that are already recorded inside the EHR system of the patient’s PCP?

The government, in its push to encourage doctors to start using health information exchange (HIE), has mandated as part of MU Stage 2 the following requirements related to HIE. Eligible providers (EP) must “(a) conduct one or more successful electronic exchanges of a summary of care records with a recipient using technology that was designed by a different EHR developer than the sender’s, or (b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period.”

(As of this writing, MU Stage 2 is set to become effective on Jan. 1, 2014. But there are various groups pushing for a delay of its implementation.)

While on the topic of the electronic exchange requirements in MU Stage 2, it is important to note that exchanging information with another EHR is not the only electronic data exchange requirement mandated under Stage 2. These additional requirements include:

- Use secure and encrypted messaging to communicate with at least 5 percent of patients.
• Provide patients with the ability to view, download, and transmit their health information within four days of a patient visit and encourage at least 5 percent of patients to use this ability.
• Provide a summary of care record electronically to other providers to whom patients are referred.
• Send electronic data to immunization, cancer, and other registries.

Finally, as an additional motivator, in April 2013 the Department of Health and Human Services started to consider requiring electronic Health Information Exchange (HIE) as a condition of participation in Medicare.

Naturally, eligible providers, including dermatologists, are anxious to find out how they can take part in this exchange, not only to meet all the new government requirements but also to simplify the exchange of information with other providers, reduce medical errors, minimize costs, and improve the overall quality of patient care.

GETTING STARTED WITH HEALTH INFORMATION EXCHANGE

HIE requirements can be satisfied by exchanging data through a number of exchange environments, including:

• Exchanges set up by specific EHR vendors,
• Private exchanges set up between providers and hospital groups, or
• Regional health exchanges set up by a local or state government.

VENDOR EXCHANGE

Some vendors have integrated electronic health information exchange directly into their EHR software. eClinicalWorks (eCW), for example, has built a peer-to-peer network called P2P to which allows secure communication between providers in their P2P network regardless of the EHR system used. Users of eCW invite providers into their network to collaborate with them. Providers are located using a master search list, and faxed or emailed invitations can be sent to any provider regardless of geographical location. If that provider is not already on the P2P network, the message invites him to join and includes a link to the eCW P2P Portal. According to eCW, “P2P facilitates referrals, streamlines scheduling appointments for patients with the other providers, and enables providers to transmit patient records with attachments, including progress notes, lab results, medical summaries, and scanned patient documents.”

PRIVATE EXCHANGE

A private HIE is coordinated by a health care organization such as a hospital system or ACO, through private funding, to connect constituents in the area and align to its business goals. A provider generally needs to be affiliated with the organization to participate in the private exchange, and in many cases, needs to use the EHR designated by the hospital.

One example of a private HIE is the eHealth Connection sponsored by the Inspira Health Network in New Jersey. Inspira Health Network is a community health system comprised of three hospitals with more than 5,000 employees and 800 affiliated physicians. According to Inspira’s website, the “eHealth Connection is a network that links all Inspira facilities and its physicians, allowing participating providers the ability to exchange health information.” Inspira further describes the function of the HIE as follows: “HIE allows the sharing of your health information among participating doctors’ offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is to provide participating caregivers the most recent health information available. This health information may include lab test results, radiology reports, medications, hospitalization summaries, allergies, and other clinical information vital to your care. Certain demographic information used to identify the individual such as name, date of birth, address, insurance may also be shared.”

PUBLIC HIE

The government has loftier goals than the limited vendor or hospital networks. It seeks the exchange of information between all providers across the nation. To accomplish this public HIE, the government has funded Regional Health Information Organizations (RHIOs) and charged them with establishing HIEs for their designated regions within their states. The ultimate goal is a nationwide health information network (NHIN) which plans to connect all health care information providers, including HIEs, health plans, providers, and federal agencies through a national health exchange. (I previously addressed this topic in June 2012; see sidebar at www.aad.org/dw/monthly/2012/june/interoperability-of-ehr-with-other-practices-and-hospitals.)

To enable HIE and improve health care in its region, a RHIO can enable secure sharing of medical records in one of two ways. In the centralized model, the RHIO uploads and collects all the medical records from all of its participants and stores this massive amount of data on its own servers in its own infrastructure. In the federated model, the RHIO provides the infrastructure to facilitate the access requested by one provider to medical records stored in the systems maintained by other providers and supported on those other providers’ infrastructures. In this model, the HIE does not collect, hold, or maintain any medical records within the RHIO’s systems. There are pros and cons to each of these methods in terms of privacy concerns, costs, and speed of access.
RHIOs require patient consent before patient information may be shared. Some RHIOs have an opt-in format which requires that patients sign an agreement to permit their information to be shared. Others assume that patients give their consent unless a patient specifically opts-out.

In order to participate in a RHIO, a provider may be required to pay one or more fees including a one-time integration fee, a one-time implementation/setup fee, an annual fee for basic services, and an implementation and/or annual fee for optional premium services. Some fees are based on the number of providers and some are charged on a per-practice basis. The actual fee may be dependent on the size of a practice or the type of health system or organization. In some cases, the fees may be subsidized by a government agency or possibly a hospital system. In order for the provider to participate electronically using his EHR, the EHR must be certified for MU Stage 2 which means that the EHR has been tested to support the interoperability standards required to share data through an HIE.

In NYC, for one to five providers, the fees can range as follows:
- Integration fees from zero to $500 per practice
- Implementation fees from zero to $3,500 per practice
- Annual fee for basic services from $240 per provider to $1,000 per practice
- Premium services fees of $1,000 for implementation plus $250 for annual support

Some of the services provided by an HIE include:
- Patient record lookup to access the patient’s medical data.
- Real-time notification of a patient’s medical status or update to the patient’s provider sent through a secure email or text message. For example, a provider can be alerted via a text message that a patient was admitted to the hospital.
- Consent management.
- Direct exchange (via secure email) of medical records for a given patient:
  - To a receiving physician upon discharge from a hospital,
  - To a specialist from a primary doctor, and
  - To a practice from a lab.
- Analytics across multiple sources of clinical and administrative data.
- Quality reporting and public health reporting.
- Patient portal (for patients to access their medical records as required by MU).

**How One HIE Gets Sharing Done**

To understand exactly how HIE works within a RHIO, I spoke with Jason Thaw, a senior account manager at Healthix, a RHIO located in downstate New York where I live and the largest RHIO in New York State. Healthix connects over 250 hospitals, clinician practices, nursing homes, radiology centers, diagnostic labs, and other providers with information about more than seven million patients.

When joining Healthix, providers notify their EHR vendor so that the vendor can work with the HIE to develop the interface and set up any additional services requested by the provider. Healthix offers a single sign-on which works directly within the EHR system and enables providers to access the RHIO through a tab on their EHR.

Healthix services include patient data search, consent management, secure email, and real-time event notifications. To search for patient data, providers access the patient’s record and then click on the Healthix tab to search the HIE for other medical records associated with that patient. All data is real-time and results typically display within seconds. Therefore, as soon as a lab result is available, even if the lab test was not ordered by the provider, Healthix can retrieve it, send an alert notification to the provider, and display the results the next time any provider (with consent) queries this patient.

New York is an opt-in state. When a patient goes to the doctor, she signs a consent form allowing or denying that doctor to view any of her medical records from any other facility connected to the RHIO. The consent does not relate to sharing of the medical records, but to who is permitted to access the records.

Healthix follows a federated model and does not create a central repository of clinical information. Instead, it routes encrypted electronic transactions among participating institutions so that they may exchange patient clinical data which resides in systems behind the firewalls of the acquiring organizations. Healthix maintains a central registry which identifies which patients have information and where it can be found.

**Conclusion**

The function of HIE is to facilitate secure and efficient sharing of patient medical records between providers caring for the same patient. The goal is to reduce the cost of providing medical care and improve the quality of patient care by eliminating duplicate diagnostic testing and making records available when and where they are needed. But the system can only work if all the providers in a given community join the system. Once MU Stage 2 takes effect, more practices will join and, over time, membership fees are expected to drop. Start researching the HIE options and services in your communities by contacting the local regional extension center. Within the next few years, HIE participation will be a requirement. Now is the time to get onboard to be ahead of the curve. *dw*
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Preventing for a meaningful use audit

BY RACHNA CHAUDHARI

DERMATOLOGISTS are entering a new landscape of ever-increasing audits. They are being hit with Recovery Audit Contractor (RAC) audits for their Medicare billings, HIPAA audits for their protection of their medical records, and numerous other audits affecting their business practices. The Electronic Health Record (EHR) Incentive Program only adds to this mix of audits with the recent implementation of meaningful use audits. The Centers for Medicare and Medicaid Services (CMS) has begun pre- and post-payment audits on at least 5 percent of physicians attesting for meaningful use, and the agency is legally able to audit for up to six years after a physician attests.

CMS has stated that all meaningful use audits are performed either by random selection or based on anomalous data, such as inconsistent denominators for measures. Atlanta West Dermatology, located in Georgia, was targeted at random for a meaningful use pre-payment audit. Holley Garrett, CPM, CPC, CDC, the practice’s administrator, was first notified of the audit in April. “CMS notified our practice of the audit by sending a formal audit letter from the law firm of Figliozzi and Company to the email address we supplied when we attested for meaningful use,” she said. (An example of a formal audit letter is found at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SampleAuditLetter.pdf.) “If the email address you entered during attestation is not accurate, your practice will not be notified by any other method and CMS will automatically recoup the meaningful use payment if no response is given within three weeks. So it is important to ensure that the email address you enter during attestation is one which is regularly checked and doesn’t filter out CMS emails,” she warned.
Once a practice is notified of an impending audit, it is prudent to assign a staff member to oversee the process. CMS will require additional documentation for each meaningful use measure as well as supporting documentation for each numerator and denominator value. The auditor will expect to receive the formal meaningful use report generated by the EHR system in addition to screenshots validating specific measures. Garrett noted that “the screenshots must show the physician’s name, EHR vendor’s logo and/or product name to verify certification, as well as a date stamp to show the measure occurred during the EHR reporting period.” Her practice also had to send a letter from the EHR vendor stating that the system was certified for the full year during which the meaningful use measures were reported. CMS has posted guidance on additional documentation and examples of screenshots at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf.

The auditing agency will expect to receive all supporting documentation via a portal on its website or via first class mail. It is the practice’s responsibility to ensure the materials are in a readable format, and the auditor does not give an expected response time, according to Garrett. Her auditor did not respond until one month after her initial submission and the whole process took almost four months before she received notice that she had passed. It took another 30 – 60 days for the practice to actually receive payment. She also had to send in additional documentation when the auditor requested more information on specific measures. “It is important to realize that the auditor is not familiar with our way of practice. Don’t assume they know more about meaningful use than you,” she said. She noted that her practice had to send in additional letters from the physician explaining why she was claiming an exclusion for specific measures, clarification of various ICD-9 codes, and copies of all of the practice’s HIPAA training materials as well as business associate agreements to show the practice was meeting the security risk analysis measure. For additional help on preparing documentation for a meaningful use audit, your practice can also contact your HIT regional extension center at www.healthit.gov/providers-professionals/region-al-extension-centers-recs#listing.

Fortunately, Garrett’s practice was successful in passing its audit; however, it took a significant amount of time and work for her to gather all of the relevant documentation. She advises that practices ensure that they are backing up their attestation with relevant documentation in the form of screen shots or explanatory statements and pay close attention to the security risk analysis measure. As the meaningful use program is only expected to grow exponentially over the next several years, these types of audits will only increase and cause further regulatory pressures on practices. *dw*
A Matter of Perception

How dermatologists are viewed by other physicians — and what they can do about it
What do other physicians think of dermatologists? Are their perceptions off the mark, or is there a grain of truth there? And why should dermatologists care?

The AAD tackled the first question in 2011 when it commissioned a research firm to query senior staff and elected physician leaders at 13 medical associations. The researchers asked a broad range of open-ended questions touching on perceptions regarding different aspects of how dermatologists practice (e.g., whether they treat serious conditions or diseases), how they interact with colleagues, their contributions to patient care and medical research, and whether they give back to society.

The results of the interviews revealed that dermatologists are perceived as valuable colleagues who make significant contributions in the prevention and treatment of skin cancer and controlling chronic disease. Among the negative perceptions, five key concerns emerged: access to dermatologists is limited, both for hospital inpatient consults and outpatient referrals; dermatologists are hesitant or unwilling to treat routine medical conditions, favoring surgical cases; dermatologists are unwilling to accept insurance; dermatologists are shifting their focus to cosmetic-related services; and, dermatologists do not tend to be visible or engaged in their local communities and medical societies. >>
The AAD convened an ad hoc task force to address the perception issues raised by the interviews and explore solutions that can be undertaken by the Academy and by individual dermatologists. Dermatologists’ reputation among their colleagues matters a great deal, said the task force chair, because the health care environment of the future may likely include new models of team care with primary care physicians as gatekeepers. “If we as dermatologists are going to have the opportunity to be a part of some of these new medical care practices, it will be important for us as a group and, more importantly, as individuals to have a good reputation and respect within our community,” said Lisa A. Garner, MD, vice president of the AAD, clinical professor of dermatology at the University of Texas Southwestern Medical School, and chair of the task force. That sentiment was echoed by task force member Brent R. Moody, MD, a dermatologist in private practice in Nashville, who noted that other physicians “may not understand who we are and the value of what we do. It’s up to us to stay engaged and show them. I’m concerned about dermatologists being marginalized, and perhaps not being afforded the opportunity to be integral players in any future delivery models.”

HOSPITAL CONSULTS
Although all the task force members contacted said they do inpatient consults, it nevertheless is “a significant issue,” Dr. Garner said. “There are certainly many areas, even some urban areas, where there are hospitals that can’t get a dermatologist to see an inpatient.”

One factor underlying some dermatologists’ reluctance to do inpatient consults is the logistical barriers that can make it frustrating and time-consuming. “It’s difficult now because every hospital has its own EHR system, which you might not be trained on,” said task force member Barbara M. Mathes, MD, clinical associate professor of dermatology at the Perelman School of Medicine at the University of Pennsylvania. “Many institutions require that you log in onsite every so often to change your password; you can’t do it from an outside computer. These are not intended to be obstacles, but they are for a dermatologist who goes to the hospital infrequently, and some dermatologists think it’s just not worth the hassle.” The task force is exploring ways to work with organizations, such as the American Hospital Association, that might encourage hospitals to make it easier for consulting physicians to navigate the

A Matter of PERCEPTION

STRATEGIES TO IMPROVE ACCESS TO THE DERMATOLOGIST’S OFFICE
A key concern among dermatologists’ physician colleagues is the difficulty they face in getting their patients in to see a dermatologist, particularly urgent or emergent cases. Two members of the AAD’s ad hoc task force addressing the perceptions of dermatology by others in the house of medicine have suggested steps that dermatologists can take now to alleviate the problem.

Suzanne M. Connolly, MD, emeritus professor of dermatology at Mayo Clinic in Scottsdale, Ariz., noted that dermatologists can:

- Keep some slots open, preferably at the beginning or end of the morning and afternoon session. Don’t fill them until 24 hours ahead, reserving one or two until eight hours ahead.
- If you know a staff shortage will be occurring, set aside a few slots in addition to those normally reserved.
- For established patients who call in concerned about one “spot,” arrange to see these patients early in the morning, before other patients.
- Utilize teledermatology within the institution to facilitate triaging patients who are more urgent.
- Group patients who share a condition (such as sore mouth or dermatitis) for general education regarding the disorder and its management and workup. You will still need to see these patients individually for history, exam, and finally summary session, but group education may free up some slots.
EHR requirements, Dr. Garner said. In the meantime, she maintained, “an individual dermatologist can try to negotiate with their hospital. They like to tell us that these things are set in stone, but they’re often not.” In Nashville, “hospitals understand the logistical problems, and they make it really easy for me,” Dr. Moody said. “In general, if dermatologists are willing to do consults, the medical staff will appreciate that and accommodate their needs.”

Another reason for not doing inpatient consults is low reimbursement, Dr. Mathes said. Compound this with logistical and inconvenience factors (few dermatologists have offices in hospitals, making it difficult to see consults during a short break in one’s schedule), and the possibility that the patient’s problem is not urgent and could be managed in the office, she said, and one can understand why dermatologists may not consider hospital consults a priority.

ACCEPTING REFERRALS
Getting patients access to a dermatologist’s office “is probably one of the biggest issues for other health care providers when they think of dermatology,” Dr. Mathes said. “There is a distribution issue. Some parts of the country are underserved; even within the same city, there are clusters of dermatologists in some areas and few or no dermatologists in other areas.” This is a challenge, she said, as is the problem of large geographic areas that are wholly without a dermatologist.

One approach to alleviating the problem is educating primary care physicians to evaluate dermatologic conditions “so that only patients who really need the dermatologist to diagnose or manage their care are referred to a dermatologist,” Dr. Mathes said. “I teach dermatology at the annual meeting of the American College of Physicians — I’ve been doing it probably more than 20 years — and typically it’s about very common skin conditions that they see, ways they can manage those conditions appropriately, and which are the critical conditions that must go to a dermatologist.” With more appropriate referrals, she said, “dermatologists are more likely to say, ‘I’m happy to do that.’”

Teledermatology is another tool that dermatologists can use to address both the inpatient and outpatient sides of the access issue. “Penn dermatologists pioneered a program (led by Dr. Carrie Kovarik) using the Academy’s [AccessDerm] program in areas of Philadelphia where no

Leonard J. Swinyer, MD, a dermatologist in private practice in Salt Lake City, described four different types of “hold” appointments, noting that “whether or not we put any or all of these into an individual provider’s schedule depends on how far out they are scheduling and how busy they are.”

- Emergency appointments are meant to be filled on the day of the appointment only, and are reserved for patients who must be seen the same day. Generally, one is in the later morning and one is in the afternoon; if they’re not filled by 9 a.m., they’re released for general scheduling.
- Consult appointments are given to patients whose physician offices call directly for appointments. There is usually one per day on the schedule; they are released to general scheduling if they’re not filled a week before the appointment date.
- “Hold” appointments are for the use of the front desk receptionists who are scheduling patients as they leave. There are usually three or four on the schedules of the busiest providers; they allow the provider to see a patient in two to three weeks when the regular schedule is four to six weeks out.
- Surgical appointments are 45- to 60-minute slots set aside for surgical procedures. The practice normally blocks out one or two per day to ensure that excisions can be accommodated. If they’re not filled a week before the appointment date, they are released for general scheduling.
dermatologists are on staff, and in community health centers where it’s unlikely they’ll have dermatologists seeing patients,” Dr. Mathes said. “There are obstacles — issues related to state regulations and compensation; I think there are only a few states that allow you to bill patients for doing medicine in this way. But I don’t think any of the obstacles are insurmountable.” Indeed, the Academy has appointed an ad hoc task force on telemedicine to address these issues and the Board approved a pilot project at its August meeting that will help demonstrate how teledermatology can increase dermatologists’ ability to provide inpatient consultations.

The task force on perception has been brainstorming strategies that very busy practices can use to enable dermatologists to accept more referrals from other physicians, Dr. Garner said (see sidebar, p. 26). But one approach the task force sees as “problematic” is that some practices put emergency referral appointments on the schedules of nurse practitioners or physician assistants without oversight or evaluation by the dermatologist, she noted. “When you’re referred an emergency patient from another physician, we believe it can appear to show indifference if the patient is put on the PA or NP schedule and not seen by the dermatologist,” Dr. Garner said. “The referring physician might well say, ‘Hey, that’s not what I was asking for.’”

When a dermatologist does see a referral, it’s not just best for the patient but also good business and good manners to follow up with the referring physician, said several task force members. “One of our challenges is to make sure we’re communicating,” said Julie Hodge, MD, a solo practitioner and assistant clinical professor at University of California – Irvine School of Medicine. “Every time a patient tells me who their primary care physician is, and certainly every time I treat a referral, I send the primary or referring physician a note about what I’ve done,” Dr. Hodge added.

Bethanee J. Schlosser, MD, PhD, assistant professor of dermatology at Northwestern University’s Feinberg School of Medicine and chair of the AAD’s Young Physicians Committee, insists that the simple step of keeping the primary care physician informed “increases the presence of dermatology, which is always a benefit in building a practice; it says you’re responsive and communicative, which is only beneficial in terms of personal and professional relationships; and I think it says that we want to be part of the bigger house of medicine.”

**CONFRONTING THE MYTHS**

While access is clearly an issue that is broadly recognized and already being addressed by dermatology, perceptions of dermatologists relating to insurance and specialization in surgical procedures or cosmetic treatment may reflect a complex set of circumstances that vary according to region. “The majority of dermatologists participate in Medicare, but we hear all the time that dermatologists don’t take Medicare,” Dr. Mathes said. “Rarely do physicians in any specialty get paid the amount billed to the insurer. If you’re in an area covered by insurers that pay notoriously low reimbursements, you may not be participating with those insurers. And frankly, other docs in your community probably are not participating either.” Forging relationships with primary care providers, and occasionally reducing or waiving the fee for their low-income patients in need of care, can go a long way toward improving the misperception, Dr. Mathes said, adding that “we have to demonstrate, make the case, that we are better than the myths about us.”

The notion that dermatologists are hesitant or unwilling to treat non-surgical cases is another misperception, Dr. Mathes said. “There certainly are some non-Mohs dermatologic surgeons who only want to excise or do other procedures, but I don’t think that’s common. Now, if there are a limited number of derms in your community, and you refer all the [medical dermatology] cases to your PA, then the perception may be correct in that particular case. But I don’t think that is universal across dermatology.” On the other hand, Dr. Schlosser noted, “the reimbursement system today favors procedural intervention, and that’s not unique to dermatology. In the end, people do have to sustain a living and make it viable for their staff.” In addition, “in some areas they’re so busy fighting the epidemic of skin cancer, it doesn’t leave a lot of room for other things. And the aging population is only going to contribute to that further.”

The Academy’s own practice survey data will require all of dermatology to improve our perception. It starts with the individual, but then it has to grow.
contradicts the stubborn myth of dermatologists’ focus on cosmetic treatment. In 2009 and 2012, time spent on patient care broke down as 67 percent medical, 25 percent non-cosmetic surgical, and 8 percent cosmetic. “One of our problems is the only time you see dermatology ads, they’re all for cosmetic procedures, and there’s often a medi-spa associated with the practice and the advertisement,” Dr. Garner said. “That’s what people see, so they begin to believe that all dermatology practices are only interested in cosmetic dermatology patients. I’m not quite sure what to do about that misperception.” Dr. Hodge said her own experience reinforced that interpretation, and prompted her to change her website. “I was surprised I was perceived that way, because I do 70 percent medical dermatology, and I always have,” she noted. “But then I looked at the things I had done marketing-wise, and it was in that [cosmetic] arena. I like to do some [cosmetic procedures], but I also realize they are important to the bottom line because they allow me to do the other things and not worry about it.” She doesn’t see a clear separation between medical and cosmetic dermatology, she added, because “anyone who has a skin problem has a cosmetic problem. And I’ve always seen that as the case, and I feel it’s my responsibility to take care of everybody. I don’t have different slots for medical and cosmetic patients or different waiting rooms. I try to address the medical and cosmetic needs of all my patients. I don’t want anyone to feel like a second class citizen. Dermatologists are lucky to be in a position to balance a mix of patient problems and procedures. This is what I love about being a dermatologist.”

Dr. Mathes again emphasized the importance of maintaining strong relationships within the medical community: “We need to make clear to our colleagues in medicine, as well as to the community, that patients coming in for cosmetic medicine may also be getting a dermatologic evaluation for other things, particularly skin cancer. It’s an education thing, but also a relationship issue.”

ENGAGEMENT THE KEY
The theme that underlies both the misperceptions of dermatologists and the path to correcting them, said the task force members, is engagement — with the hospital staff, with individual primary care physicians, with the community, and with local and state medical societies. At the leadership level, Dr. Garner said, the task force is “trying to interact with larger national primary care organizations to find out what they see as their greatest needs that we could address. What does their leadership see as a way to improve our interaction, how can we do a better job at providing what their members need from dermatology? We don’t really know what that is.” Dr. Mathes emphasized the importance of interaction among specialties, noting that “everyone wants to hear dermatologists talk. We should encourage our members to speak at local, regional, and national meetings. But we should also invite them into our house so that we have mutual respect for each other. I think if this is done on the leadership level, it will demonstrate the importance and the commitment we have as a specialty society.”

One area of focus should be the hospital, Dr. Moody said. “Part of our problem is our success in treating patients in the outpatient setting,” he explained. “This is wonderful for patients, and cost-effective, but the downside is lack of visibility in the hospitals. The dermatologist who is engaged in some type of hospital activity, such as taking a committee assignment, is helping to counteract some of those negative perceptions people have of us being disengaged or unavailable or uninterested.”

The Young Physicians Committee is actively “trying to encourage broader participation by dermatologists in the house of medicine,” Dr. Schlosser said. “Sitting on various hospital committees, participating not just in state and local dermatology societies but also state and county medical societies. By doing that you are automatically saying that dermatology cares about more than just itself. And, from a self-preservation standpoint, if we’re not sitting at the table, we will not have a voice in decisions about licensure requirements, certification, scope of practice issues — people will be making those decisions for us.” The youngest member of the task force, Karolyn Wanat, MD, who recently completed a dermatopathology fellowship at the University of Pennsylvania and joined the faculty at the University of Iowa as a clinical assistant professor, remarked that “creating a culture” of engagement among dermatology residents involves promoting volunteerism and activism, and “establishing relationships with primary care physicians in the area so that they can help get patients in when they need to. It will require all of dermatology to help improve that perception. I think it starts with the individual, but then it has to continue to grow so that others are aware of what we can accomplish together as dermatologists.”
MOVING UP, MOVING OUT

Dermatologists detail the moving process, from cross-town to cross-country
The process of moving a practice, whether it’s down the road or to a different time zone, brings with it opportunities and challenges which can run down even the most enthusiastic practice owner. By planning well in advance, gleaning the lessons of colleagues’ experiences, and resolving to make oneself adaptable, practitioners can greatly ease one of the more intimidating events of one’s medical career.

THE ‘LIGHTNING BOLT’ MOMENT
For every dermatologist who moves their practice, there’s an identifiable moment where the “should I?” of moving becomes “how do I?” according to dermatologist Neal Bhatia, MD, who in 2010 left his Milwaukee practice for private practice in California and a position as interim program director of the division of dermatology at Harbor UCLA Medical Center. >>
MOVING UP, MOVING OUT

“For me, there were a number of personal factors that went into the move, as well as the fact that a group of physicians I was affiliated with was sold to a hospital system, which can be a disaster for a dermatologist,” he said. “Between that and wanting to move closer to family, I made the decision fairly quickly. The minute you make that decision, it’s important to start making preparations. In my case, it was six months in advance.”

Other physicians are driven to relocate because of expiring contracts or leases, or economic conditions that make staying in place untenable. Fort Smith, Ark., dermatologist Sandy Johnson, MD, found that her office was becoming too small for the growing practice.

“Before our move, we were renting, and we had the ability to purchase and grow,” Dr. Johnson said. “Our first plan was to purchase the clinic that we had been renting, but it turned out not to be a viable option. So that original plan was replaced by almost three years of looking for land, drawing up and modifying plans, and then carrying out the 12-month construction process.”

MANAGING THE LOGISTICS

As a physician with responsibilities to one’s patients, the moving process can be somewhat complicated. For Washington, D.C., dermatologist Andrew Lazar, MD, who has moved from practicing in Illinois to California to his new D.C. home since 2010, the very first step each time was a call to set in motion the process of becoming licensed in the new state.

“The moment you know where you’re going, you need to start the process as soon as you can, because it takes a long time to get a license,” Dr. Lazar said. “The sooner you get things started, the sooner you can be working. No matter what, get that process started as soon as you make a commitment as to where you’re going to go.”

To ease the process, Dr. Lazar recommends employing a service that will handle the paperwork and red tape of licensure. The cost involved, he said, is offset by the lack of bureaucratic headaches.

“There are a number of organizations that will actually do the busywork for you. They charge you about $600 per license to do the work. It’s not a small amount, but at the same time, I’m not calling the registrar of the medical school to make sure a form was sent or calling the head of residency to make sure it’s sent on the right stationery,” Dr. Lazar said. “During the last move, I was told by the person who is working on my applications that one of these licensing agencies has requested copies of where I trained and did my residency four different times. It was sent four times through the service, but they didn’t have a record of receiving it. It was worthwhile for me not to have to deal with that.”

In addition, Dr. Bhatia recommends that young physicians in residency look ahead to future licensing situations, obtaining licenses for their states of training and home states, in addition to where they plan to practice initially.

“The best advice that I can give anyone in residency is to get the license of the two states that you think you may move to in your lifetime,” Dr. Bhatia said. “Even if you don’t keep them up, you can re-enroll when you move there because you already have your foot in the door. I was able to get set up in California much more quickly this way because I’d applied for a license there during residency.”

After licensure is dealt with, there remains the issue of malpractice tail insurance. Typically, insurers will offer either a one-time payment option or a slightly more expensive multi-year pay period. Academic institutions, Dr. Lazar said, will sometimes cover the insurance themselves, depending on the length of one’s employment. Large groups, he said, can also be persuaded to cover the payment as part of their expenses.

“Doctors never think about the fact that you can negotiate give and take between a group or institution. There’s a lot of give and take depending on the size of the organization you’re dealing with,” Dr. Lazar said. “Most of us aren’t used...
to that. We don’t think about the business aspects of it, and it’s important to realize it.”

Enrolled Medicare providers must also report changes in address to their contractor to ensure the least possible disruption in payment. While earlier is better, according to Dr. Lazar, under the law, one must report the move within 90 days. Whether a doctor is moving or becoming a Medicare provider for the first time, he or she should visit www.cms.gov/MedicareProviderSupEnroll to learn about the requirements and/or update his or her entry in Medicare’s Provider Enrollment, Chain and Ownership System (PECOS).

If one is splitting a dermatology practice from a group, Dr. Bhatia said, it’s important to address the accounts receivable situation as quickly as possible. The nature of the split, he said, often dictates the financial arrangement.

“Some groups will offer you either sustained payoffs over time or you can take an immediate lesser buyout, as you would from the lottery, rather than the long-term payout of what is truly owed you,” Dr. Bhatia said. “If it’s an amicable split, a lot of people will take the longer payout. If not, most people will take the immediate buyout. There’s an upside and a downside to both, depending on your situation.”

**GETTING THE WORD OUT AND STARTING ANEW**

The process of informing and transitioning patients, Dr. Bhatia said, is a multi-step one. Once he had informed his affiliated physician group (90 days before he intended to move), Dr. Bhatia began to plan for his patients’ futures, taking on fewer and fewer new patients and beginning to send follow-up cases to colleagues in the area.

“As 90 days turns into 60 days, you’re starting to make patients aware that you’re going to be gone or that you’re going to be seeing them for the last time, which can be very sentimental,” he said. “From there, you’re also making sure that those patients with melanoma or high-risk therapies are getting their future care addressed sooner rather than later. You don’t want them falling through the cracks.”

Depending on the state that one is leaving, there are a number of varying responsibilities upon the physician to ensure they have done their best to notify patients.

“When I was in Illinois, I talked to the state medical society and found out what the legal obligations were to close your practice. There, you had to post a notice in the newspaper a certain amount of time in advance,” Dr. Lazar said. “In dermatology, you don’t have many true emergencies. In the case that you do, whoever took over the practice or who you referred the patient to would get the phone call.”

Some physicians make efforts to notify each patient individually, but according to Dr. Lazar, doing so can incur substantial cost.

“In dermatology you might have 40,000 active charts in your practice. To try to contact all of those people is an exceptionally difficult and exceptionally expensive process. It’s going to cost you about a dollar per contact.”

Instead, Dr. Lazar posted the legal notice in the paper, then made arrangements with the physicians taking over his two practices to take over the phone numbers of the practice and notify each patient as they called. The charts remained where they were, he said, which greatly improved the continuity of care.

Even for cross-town moves, Dr. Johnson said, a select number of patients may miss all the signs and notifications.

“We’ve been in our new location for two-and-a-half years. When we moved, we took out ads in the paper, bought a billboard near the old location for a few months, mailed notices, and sent out messages with our automated messaging machine,” she said. “We still have patients going to the old location. It’s important to promote the move not only months ahead, but for some time afterward.”

In addition to patients, Dr. Johnson said, insurers may require more than one notification, or at least a follow-up to make sure that the payment transfer proceeds smoothly. More than one payer, she said, had trouble with the change of address that resulted in a two-month delay in payment.

Contract language may prevent some physicians from informing the patients about anything but the fact that they’re moving. Birmingham, Ala., dermatologist Elizabeth Martin, MD, negotiated with the clinic system she was leaving — for a location literally across the street — on the method she would use to notify patients of her move. Eventually, she sent each patient a postcard with a map of the new location in relation to the old one.

“While they weren’t too happy about me leaving, it was a fairly amicable breakup,” Dr. Martin said. “We agreed mutually upon the wording on the card.”

Some physicians have an even more difficult time. In a recent Leadership Institute session she was leading at the Summer Academy Meeting in New York, Dr. Martin answered an attendee’s inquiries about notifying patients of his impending move under the strictest of contractual tethers. The dermatologist, she said, was allowed to tell patients he was moving, but nothing more than that.

“That’s a difficult situation for a dermatologist, not being allowed to contact any patients,” Dr. Martin said. “We got a discussion going, and the general recommendations were to make sure his information was up to date and easy to find via Google, and tell patients that they could search for him after the move.”

Even if one leaves the practice in another dermatologist’s hands, Dr. Bhatia said, it’s typically good business to make oneself available for the new practice owner and patients for a short period of time following the move.

“You want to maintain as much good faith as you can so that you can leave on a positive note,” he said. “Ultimately, you want to leave a good legacy.”

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**GETTING UP TO DATE**

Moving your practice? Update your information with the Academy at www.aad.org/Account/Profile, or through the Member Resource Center at (866) 503-7546.
Dermatologists on the front line in detecting venous disease
According to the Vascular Disease Foundation, six million people in the United States have skin changes associated with chronic venous insufficiency.

Although venous disease is often addressed by a range of medical specialists, because of these skin changes, dermatologists are often on the front line in detecting this condition.

Elevated blood pressure in the superficial venous system that occurs during walking, which results from a clot or other venous system destruction with valve breakdown, can result in leaky veins, said David Margolis, MD, professor of dermatology and epidemiology at the University of Pennsylvania. Therefore, varicose veins, edema, dermatitis, ulcers, and blood staining of the skin can occur.

“Dermatologists are often trained to take care of wounds so they understand the concepts of good wound care, sometimes better than others,” Dr. Margolis said. However, an integrated approach — drawing on the expertise of vascular surgeons, podiatrists, and other specialists — remains important.>>
DIAGNOSING VENOUS DISEASE
A careful patient history and examination reveal critical details. Often surfacing in women in their 40s and men in their 60s and 70s, venous insufficiency occurs more commonly in the Western world. Risk factors include family history, a history of deep vein thrombosis, obesity, and multiple pregnancies, among others. Those required to stand for lengthy periods at work may also be more prone to this condition if they are predisposed.

“We do more full-skin exams than any other specialty,” said Girish (Gilly) Munavalli, MD, MHS, medical director of Dermatology, Laser, and Vein Specialists of the Carolinas, PLLC, in Charlotte, N.C., and assistant professor in the Wake Forest University department of dermatology, giving dermatologists a unique opportunity to evaluate the vascular status of their patients.

On physical examination, clinicians should search for signs such as bulging veins, stasis dermatitis, skin breakdown, and swelling. “Anything that you see should prompt you to just ask a couple of simple questions, like, ‘Do you have a family history of varicose veins?’ or ‘Do your legs bother you? Are they achy?’” Dr. Munavalli said.

When spider veins appear on the calf, it’s important to examine the back of the patient’s legs. “If you don’t look at the back of the knee or thighs, you’re not going to realize that they have a varicose vein there that’s contributing to the spider veins lower down,” said Margaret Weiss, MD, of the Maryland Laser, Skin, and Vein Institute in Hunt Valley, Md.

“When groups of spider veins and associated blue veins are on the medial side of the leg, there’s a high probability, probably 80 to 90 percent chance, that they’re coming from a leak in the great saphenous vein,” said Robert Weiss, MD, director of the Maryland Laser, Skin, and Vein Institute. However, he continued, if they’re on the lateral part of the leg, they can usually be attributed to the lateral subdermal venous system.

Diabetes, hypertension, and other conditions can mask the signs of venous disease in the lower legs, Dr. Munavalli said, because they cause lower leg skin changes and potentially leg swelling. Lymphedema can demonstrate similar characteristics, such as edema, skin changes, heaviness, and pain, he explained. “Venous disease onset is insidious and can also manifest with episodic swelling of the legs and stasis dermatitis around the areas of bulging veins,” he said.

Duplex ultrasound is an essential tool in diagnosis. “Most dermatologists don’t have this tool in their offices, so you really need to develop a referral relationship with a vein center or another colleague who does a lot of superficial venous ultrasounds,” Dr. Munavalli said, such as a vascular surgeon. Duplex ultrasound “is non-invasive, quick, and gives information on abnormal flow in the veins,” he said. It can also measure the abnormally large veins that result from longstanding distension.

WEIGHING TREATMENT OPTIONS
A decade ago, patients with vein damage often needed vein stripping; however, outpatient treatments have emerged that reduce the need for more invasive procedures.

Dr. Robert Weiss and Mitchel Goldman, MD, were key developers of endovenous ablation technology, which destroys the vein so it eventually will become reabsorbed. “That really revolutionized the treatment of leg veins, and because so many people now have access to that, we predict that the number of people with leg ulcers from chronic venous insufficiency is going to go way down and it’s actually going to reduce our health care costs,” Dr. Robert Weiss said. He explained that patients often delayed seeking the stripping procedure, but endovenous ablation, using diode or Nd-YAG lasers, is performed with a single puncture.

Major leg veins with leaky valves typically are treated with endovenous ablation (laser or radiofrequency), Dr. Margaret Weiss explained. “After that major leakage is shut down, then one can generally treat remaining varicose veins either with sclerotherapy or sometimes with ambulatory phlebectomy,” she said. “Many times telangiectasias don’t have significant underlying reflux and they can either most commonly get treated with sclerotherapy or they can be treated sometimes with lasers.”

Another advance in the treatment of abnormal veins, the sclerosant polidocanol (Asclera), was cleared by the U.S. Food and Drug Administration in 2010 to treat spider veins and small varicose veins. “Now that it’s available, it actually is a great benefit to patients,” Dr. Robert Weiss said — physicians who previously used polidocanol had to obtain it from compounding pharmacies, but today they can use a true pharmaceutical grade version. Peterson and colleagues reported a study comparing polidocanol and hypertonic saline sclerotherapy in the August 2012 issue of Dermatologic Surgery. In this study (funded by Merz Aesthetics, which distributes Asclera in the U.S.), both agents were effective, but patients experienced less pain with the new formulation.

“Foam sclerotherapy has been a big advance,” Dr. Robert Weiss added. (Injecting the sclerosant as foam rather than a liquid allows it to make contact with a higher percentage of the inside of the vein.) However, he noted, the FDA differentiates between injecting a sclerosant as a liquid or a foam, so foam treatment is currently off label. “What [foam] allows you to do is to treat more precisely because you can see where the foam displaces the blood,” he said. “You can do it just as far as you want and then stop. The other big advantage is that, because these are all microbubbles, on the surface of each microbubble you have the full concentration of the solution without being diluted by blood, so it makes it a more effective sclerosing agent and more precise.”

New sclerosants are working their way through the pipeline, according to Dr. Munavalli, who directed a forum on treatment of varicose and telangiectatic veins at the
American Academy of Dermatology’s 2013 Annual Meeting. “Some of the things coming down the line are new, more potent sclerotherapy agents that are better able to destroy the vein without spreading outside of that area,” he said.

**TREATMENT SIDE EFFECTS**

Major adverse events from sclerotherapy are solution dependent, Dr. Robert Weiss said. “You can get a little skin breakdown or ulceration where the solution was injected. It’s highly unlikely, though, with the newer solutions,” he said. Because he believes hypertonic saline carries the highest risk of skin breakdown, he tends to avoid it.

For patients with widespread networks of problem veins, Dr. Margaret Weiss encourages testing with varying concentrations of solutions and foam vs. non-foaming agents to determine whether a patient is susceptible to hyperpigmentation or matting.

“Matching the concentration of the sclerosing solution to the size of the vessel is really important,” Dr. Margaret Weiss said. “In other words, you want to use the minimum concentration of sclerosant for a particular size vessel and then have the patient wear compression stockings after the treatment for anywhere from one to three weeks.”

Post-treatment compression helps reduce the risk of hyperpigmentation. Meticulous attention to technique is also essential so the solution does not leak into the surrounding skin, resulting in ulceration, she explained.

Dr. Margaret Weiss also advised using the smallest amount of solution needed. “The risk of a deep blood clot is fortunately extremely low with sclerotherapy and using the appropriate amount of solution and compression stockings, having the patients...ambulatory after their treatment, that’s helpful in reducing that risk,” she said.

**FACILITATING WOUND HEALING**

Venous disease can lead to ulcers. Because it is not the only cause, though, clinicians should start the wound-healing process by ruling out other potential causes of ulceration. “Sometimes there are mimickers of venous ulcers; anything from cancer to inflammatory conditions can sometimes look like a venous ulcer,” said Robert S. Kirsner, MD, PhD, professor, vice chairman, and Stiefel laboratories Chair in the department of dermatology and cutaneous surgery, and chief of dermatology at the University of Miami Hospital School of Medicine.

In addition to performing a physical examination and vascular or arterial studies, clinicians may also perform biopsies to exclude other wound causes if a wound is not improving.

Primary wound dressings usually help keep the wounds moist, and some ulcers may need debridement — especially when chronic ulcers have devitalized tissue, Dr. Margolis said.

Dr. Kirsner explained that compression wraps are the mainstay of treatment for venous ulcers. “The problem is that it is a difficult treatment for patients because they are meant to be left on so it does affect their lifestyle,” he said.

To achieve optimal results with compression wraps, it’s important to choose the correct wrap and ensure it will not create problems; for example, if elastic full-strength wraps are used in patients with inadequate arterial flow, skin necrosis could occur, Dr. Kirsner said.

Two types of compression wraps exist: inelastic and elastic. Inelastic wraps harden, providing compression when the patient walks, whereas elastic wraps constantly squeeze the leg. “So typically elastic compression is better than inelastic compression, and systematic reviews have confirmed that multilayered compression bandages are better than a single layer of compression,” Dr. Kirsner said.

“For the average-sized wound (<10 cm²), about a 30 to 40 percent size reduction in a month is a good indicator of whether or not the wound is going to have a chance to go on to heal,” Dr. Kirsner continued. If the wound hasn’t reduced in size by one month of treatment, the clinician should consider adding one of several available adjunctive therapies that have been successfully used with compression wraps to speed healing. “There have been studies with aspirin and with pentoxifylline given orally that will speed the healing of venous ulcers when used with compression wraps,” Dr. Kirsner said. Jull and colleagues reported on pentoxifylline in treating venous ulcers in the 2012 Cochrane Database of Systematic Reviews. “There are also biologic and synthetic extracellular matrices or acellular constructs that have been shown in studies to speed the healing,” Dr. Kirsner said. Kelechi and colleagues investigated the use of a poly-N-acetyl glucosamine nanofiber-derived wound-healing technology in a pilot study reported in the June 2012 issue of the Journal of the American Academy of Dermatology, and Mostow and colleagues reported on a biomaterial derived from porcine small-intestine submucosa in the May 2005 issue of the Journal of Vascular Surgery. In addition, Dr. Kirsner explained, bilayered engineered cellular constructs grown in the laboratory have level I evidence to support their use.

**REDUCING VENOUS ULCERS**

Dr. Margaret Weiss hopes venous ulcers eventually become a thing of the past. If venous insufficiency is treated before changes such as dermatitis, chronic edema, and skin breakdown occur, clinicians can help prevent these consequences, “so they wouldn’t get a wound that needed to heal,” she said.

_Editor’s note: Dr. Margaret Weiss has no financial interests related to her comments. Dr. Kirsner is a consultant for 3M, Healthpoint Biotherapeutics, and Organogenesis. Dr. Margolis has served as a consultant for Healthpoint Biotherapeutics, Organogenesis, and Shire Regenerative Medicine; he also has served on an advisory board for Celleration. Dr. Munavalli has been an investigator for BTG (makers of Varisolve) and CoolTouch, a laser used to perform endovenous ablation, and is medical director of Merz Aesthetics, which produces Asclera. Dr. Robert Weiss previously served as a speaker for Merz Aesthetics. dw_
Volunteerism can improve perspectives

BY DIRK ELSTON, MD

It’s an interesting time to be a dermatologist. In the last few months you’ve heard a lot, from me and from others, that may alarm you — and if you haven’t, I encourage you to get online and read about some of the pressing issues that face our specialty. Member to Member, our official biweekly e-newsletter, is running a series about them; check it out every other Friday and online at www.aad.org/members/publications/member-to-member. You’ve also been reading about these issues in Dermatology World; last month’s cover story (available online at www.aad.org/dw/monthly/2013/september/shifting-sands, if you missed it) explored the changing reimbursement landscape, while this month’s addresses concerns about how our profession is perceived by our colleagues in medicine. More about that in a moment.

First, though, think about why you chose to become a dermatologist. Was it so you could obsess about how much Medicare would pay for a particular procedure? Was it so you could become expert at medication preauthorization? Or did you, like me, become a physician to make a difference in people’s lives? As dermatologists, we have the daily satisfactions of providing immediate relief to patients, of being able to deliver results they can see and appreciate, and each melanoma identified early is a life saved.

We make a difference each day when we go to work, whether we’re advising a patient with refractory urticaria, excising a skin cancer, identifying a contact allergen, or diagnosing melanoma on a biopsy slide. But it’s easy to get so caught up in the headaches of running a practice that we forget how important our day-to-day work is to each patient. Step back for just a moment and examine how many lives you impact each day. It’s a good feeling. Practicing efficient, cost-effective medicine can help preserve patient access to our specialty at a time when every specialty has to prove its value.

There are other ways of making a difference that also reinforce our identity as physicians and healers — small acts of kindness that can have a huge impact. Helping to guide a patient with limited resources toward the most cost-effective treatment may determine what they can afford to eat for the next month. Taking a moment to listen and allay the fear and anxiety that surrounds a cancer diagnosis. Expressing empathy for the stress of a child with refractory eczema who can’t sleep at night. People who take advantage of the many small opportunities to impact people’s lives are happier at work; and those who are happy at work are more highly regarded by their patients. It’s an upward spiral.

Volunteerism is another great way to make a difference in the community. Whether it is medical work, Camp Discovery, or coaching little league, volunteering makes a difference in your own life as well as the lives of those you help. One of my greatest joys is volunteer teaching, and acting as a volunteer attending. In addition to providing care to an underserved population, it helps me connect to a new generation of physicians full of eagerness and excitement about dermatology. Their enthusiasm rubs off. Finding a meaningful way to contribute gives one a better perspective on what it all means. Many volunteer activities provide an opportunity to reconnect with old friends while accomplishing something worthwhile. It energizes you and the positive energy filters back into your own practice. But don’t take my word for it. I invited some of our colleagues to explain why they volunteer; see what they said on the next page.

Returning to the perception question addressed on this month’s cover: When we engage in activities that nourish our souls, we radiate a more positive image to our patients, our colleagues, and our families. Our good works don’t just change our perspectives — they can also help change the perspectives of those around us. In a time when those perspectives matter more and more, that is no small added bonus.

Wondering how to get started, or looking for something new? The Academy has plenty of options for you; visit www.aad.org/members/volunteer-and-mentor-opportunities to learn more.
WHY DO DERMATOLOGISTS VOLUNTEER?

“Volunteering at Camp Discovery vaccinates me. It reminds me that patients with skin diseases are real suffering people. It refreshes my commitment to really care about my patients and try harder to really help them.”
– Mark Dahl, MD

“The Academy’s teledermatology program, AccessDerm, is a convenient and rewarding way to serve America’s vulnerable citizens.”
– William James, MD

“Volunteering my time to run the dermatology service in Botswana has been one of the most rewarding aspects of my career. Not only do I get to provide care to a population with great need, but I also mentor young residents in their rotation there through the AAD Resident International Grant. The participating residents often describe this rotation as an incredibly enriching experience that has a profound effect on their dermatology careers and lives in general. It is my hope that I am able to even slightly influence this next generation to continue and expand a culture of volunteerism within our specialty.”
– Carrie Kovarik, MD

“Camp Discovery offers physician volunteers many ways to interact with and influence the lives of children with chronic skin disorders. In addition to helping with the campers’ medical needs, dermatologists have helped with arts and crafts activities, led bike hikes, taught harmonica lessons, or simply served as a friend and surrogate parent. The rewards of service are countless and most of us have found our own lives to be enriched far more than we can ever hope to give back to camp.”
– Howard Pride, MD

“For me volunteerism is a natural part of medical practice and something that gives one great satisfaction...I feel very blessed that I am able to do so and help communities with the training I have been lucky to receive as a dermatologist. Another great part about volunteering is getting medical students, residents, and fellow colleagues involved to serve and get involved with community service.”
– Aisha Sethi, MD

“Dermatologists and other physicians are some of the most fortunate people in the world. It is a privilege and honor to do the work we do. I think giving something back is a duty we all have.”
– Paul Storrs, MD

“I have volunteered at Camp Discovery for 14 years. It has definitely made me a better pediatric dermatologist. Having performed daily skin care on children with severe ichthyoses, atopic dermatitis, and epidermolysis bullosa, I have practical skills that you do not get from seeing patients in clinic. But what the experience best provides is an insight and empathy into what the daily lives of these children are like, their struggles with pain and the amount of time involved to care for their skin. But the best part is seeing the joy and happiness of the kids, just being kids. It is the smiles, laughter, and giggles that make Camp such a special place.
I have volunteered internationally as well, having been to Tanzania at the Regional Dermatology Training Center and also in Iquitos, Peru with Penn State’s Global Health Scholars Program. It is a completely different experience than Camp. Volunteering abroad is a means of giving back and to see the world beyond the walls of an academic medical center. I am extremely blessed to live in a resource rich country with excellent training. Teaching abroad, seeing and helping patients with the greatest need with limited resources, is a grounding and humbling experience.”
– Andrea Zaenglein, MD
academy update

AAD, AADA Boards adopt position statements, set priorities at August meeting

The Board of Directors of the American Academy of Dermatology Association adopted a new position statement at its Aug. 3 meeting that positions the organization as “proactive in addressing the physician shortage in this country.” The statement, on graduate medical education, calls for Congress to “remove the freeze on Medicare-supported residency positions that has been in effect since 1997” and for an increase in slots of 15 percent overall, with half of the new residency slots allocated to specialty training, including dermatology. The AADA Board also approved revisions to its position statement on generic therapeutic and biosimilar substitution that call for adverse event tracking for generics and biosimilars as well as notification to the physician prior to dispensing. Both position statements are available online at www.aad.org/Forms/Policies/ps.aspx.

The American Academy of Dermatology Board approved the creation of a new Professionalism Award, to be awarded as-warranted, that will be “presented to a medical professional or organization in recognition of the recipient’s exemplifying the highest standards of professionalism over a career or substantial period of time.” Details about the award and how to submit a nomination will be available at www.aad.org/members/awards-grants-scholarships.

The AAD Board also approved the use of rotating taglines on AAD.org. In addition to the Academy’s “Excellence in Dermatology” tagline, visitors to the website will see taglines referring to excellence in areas including medical dermatology, dermatologic surgery, and dermatopathology, and each area will be highlighted on the home page slideshow.

The Board also approved a pilot project to demonstrate the value of teledermatology in improving the ability of dermatologists to provide inpatient consultations for patients with dermatologic complaints. More information will be available as the project is developed and rolled out. – RICHARD NELSON

Harold O. Perry, MD, former AAD president, mourned

HAROLD O. PERRY, MD, who served as AAD president in 1981 and as vice president in 1976, died on Aug. 9. He was 91 years old.

Dr. Perry completed his medical degree at the University of Minnesota in 1946, then served in the U.S. Naval Medical Corps from 1947 to 1949. He completed his dermatology residency at the Mayo Clinic in Rochester, Minn., in 1952, and later served there as professor of dermatology and chairman of the medical school’s department of dermatology.

In addition to serving as president of the AAD, Dr. Perry was president of the Minnesota Dermatological Society in 1965, the Noah Worcester Dermatological Society in 1967-68, the American Dermatological Association in 1990, and the American Board of Dermatology in 1990.

Dr. Perry was named an Honorary Member of the Academy in 1984. The next year he was chosen as a recipient of the Academy’s Master of Dermatology award. In 1998 he received the organization’s highest honor, the Gold Medal. The Academy’s Board unanimously approved the acquisition of its first headquarters in 1981, a decision Dr. Perry later called his greatest achievement as president. – RICHARD NELSON

Nominations sought for Master Dermatologist Award

THE ACADEMY’S HISTORY COMMITTEE seeks nominations for the AAD Master Dermatologist Award. The Award recognizes an Academy member who throughout the span of his or her career has made significant contributions to the specialty of dermatology as well as to the leadership and/or educational programs of the American Academy of Dermatology. The selected individual will be presented with the Master Dermatologist Award at the 73rd Annual Meeting in San Francisco, March 20-24, 2015.

Recipients should possess a national or international presence and a well-recognized expertise. The recipient should be a longstanding Academy member.

Requests for nominations are solicited annually from the Academy membership at large, via Dermatology World, as well as from the members of the Board of Directors and the Academy’s History Committee. The recipient will be selected by the History Committee and presented to the Board of Directors for approval.

Requests for nominations must be submitted online at www.aad.org/MasterDermatologist. For more information contact Nikki Haton at nhaton@aad.org. – NIKKI HATON
Special Thanks
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**1998 LEGACY SOCIETY**

The Academy extends its deep gratitude to the following members of the 1998 Legacy Society who have chosen to help ensure the good work of the Academy continues well into the future through a gift to the AAD in their wills, trusts or estate plans:

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- Rex and Johnie Amonette
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In recognition of the Academy's 75th anniversary, we would like to thank those donors whose cumulative gifts have exceeded $50,000. Their continued generosity has ensured the success of Academy programs and services that have enriched the lives of children and adults, made a difference in local communities, and advanced the specialty.

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Reflecting the Academy's records since 2005 and including data from years previously available.

A special thank you to all AAD members who gave in celebration of the Academy’s 75th Anniversary.

exceeded $50,000. Their continued generosity has ensured the success of Academy programs and services that have enriched the lives of children and adults, made a difference in local communities, and advanced the specialty.

American Academy of Dermatology

includes contributions through August 20, 2013. The Academy apologizes for any errors or omissions.
AAD updates patient education on acne
Addresses concerns that patients are obtaining isotretinoin online and self-medicating

RESPONDING TO REPORTS THAT SOME PATIENTS are obtaining the medication online and treating themselves with it, often using a low-dose regimen discussed on many online message boards, the AAD recently updated its patient education related to isotretinoin.

The Web page on isotretinoin now warns, in large type, “You put your health at serious risk when you buy this medicine from an online site that does not require a prescription.”

A warning about isotretinoin also appears on www.aad.org/dermatology-a-to-z, the home page of the Dermatology A to Z section of AAD.org — the most popular area of the entire website. AAD Board of Directors member Neal Bhatia, MD, encouraged his colleagues to take similar action on their own websites by adding links to the AAD website and warning patients of the potential results of buying isotretinoin online, including complications to pregnancies and the risk of receiving counterfeit medications. “Some patients will seek this medication online no matter what we do, and some side effects will go untreated as a result. But the more of us who warn against this practice, the more likely it is that a patient looking to buy isotretinoin online will think twice. Even patients on low doses of isotretinoin should be monitored by a dermatologist.”

The Academy’s position statement notes that the organization “opposes online Internet dispensing, sharing, or use without physician supervision, because these activities do not provide for sufficient patient education about isotretinoin risks and do not require participation in the iPLEDGE program.” — RICHARD NELSON
Dermatologist’s letter appears in New Yorker

University of Pennsylvania dermatologist Misha Rosenbach, MD, recently read with interest a May 13 piece in the New Yorker, entitled “Every Disease on Earth,” that addressed medical education and the importance of academic medicine and training from expert physicians.

The piece centered on a doctor at Elmhurst Hospital in the Queens borough of New York who was both an expert in unusual diagnoses and a mentor to younger physicians. In response, Dr. Rosenbach wrote a letter to the magazine addressing the bipartisan push for cuts to government-supported graduate medical education funding. (The AAD adopted a position on this issue in August; see p. 40.) “Cost containment is a laudable goal, but less funding for graduate medical education would mean fewer gifted teaching clinicians, at the expense of our nation’s health,” Dr. Rosenbach said in his letter, which was published in the June 3 issue.

As an active reader of the New Yorker and a passionate advocate of better funding for medical education, Dr. Rosenbach said the original piece struck a chord.

“I think that in a lot of hospitals and academic centers, dermatologists fill the role described in the piece. There are so many diseases that we know so much about that many doctors don’t know or have forgotten about,” Dr. Rosenbach said. “It’s important for us as a field to highlight this for our colleagues and decision makers. It’s just unfortunate that this kind of training is in the crosshairs as the government tries to reduce the cost of medicine in any way possible.”

In safeguarding medical education in particular and the future of medicine in general, Dr. Rosenbach said that it may be time for the different medical specialties to come together on a concerted effort to advocate for common causes.

“When we hear about what goes on in Washington, a lot of the issues are that each specialty and subspecialty has its own focus and goes to the Hill saying ‘we need this code preserved.’ But doctors as a whole should really work together on some issues like tort reform, the SGR fix, and especially medical education,” he said. “I think that medical education, which impacts all of medicine, could bring a lot of people together. We need to have an active voice in the medical community for these things that affect everyone.” - JOHN CARRUTHERS

Media Highlight

Thank you to the Academy members who continue to share their valuable expertise and time with the media to educate the public about skin, hair, and nail health.

In the August issue of Fitness, (circ. 1,527,912), “All Puckered Out,” Patricia Farris, MD, Bruce Katz, MD, Howard Murad, MD, Neil Sadick, MD, and Molly Wanner, MD, explain how cellulite forms and the treatments that can make it look better.

You can find other stories of interest in the Academy’s new monthly Media Update newsletter available in the Academy’s Media Relations Toolkit at www.aad.org/members/media-relations-toolkit. Media Update can keep you current on the stories your patients may see in the media and ask you about when they visit your office.

- JENNIFER ALLYN
Upcoming CME Activities

Closure Course, Fundamentals of Mohs Pathology, and Fundamentals of Mohs Surgery  
Fundamentals of Mohs Pathology is new this year!

DoubleTree Hotel San Diego, Mission Valley  
San Diego, California

October 28-30, 2013 – Closures Course for Dermatologists
Course prerequisite is basic experience in cutting and sewing skin, with program designed to take dermatologists to the next level of dermatologic surgery practice. This is an intense learning experience in closure considerations for the surgeon with a primary interest in closing surgical defects. It will feature practical techniques, site specific discussions, and numerous reconstruction “pearls,” based upon presenter’s extensive derm surgery experience.

October 29, 2013 – Fundamentals of Mohs Pathology
This one-day course is tailored to the needs of clinicians performing Mohs surgery or desirous of performing Mohs surgery, who are returning to dermatopathology after a period of years or whose training may never have included significant exposure to skin pathology. Our goal is to familiarize attendees via multiple microscopic presentations with the most common entities treated by Mohs surgery: basal cell carcinoma and squamous cell carcinoma. The course will cover all variations of these two common cancers, as well as common mimics often found within surgical tissues usually excised during Mohs procedures – including normal histologic structures and inflammatory and reparative findings. Course work will include study sets viewed by attendees using high quality Mohs microscopes and didactic lectures by faculty dermatopathologists.

October 31-November 3, 2013 – Fundamentals of Mohs Surgery for Dermatologists and Mohs Technicians
Developed as a comprehensive introduction to Mohs surgery, the course provides an overview of Mohs indications, mapping techniques, office set-up and instrumentation, and interpretation of Mohs histopathology. Instruction in key concepts is facilitated by lectures, “pearls” discussions, interactive Q&A sessions, video microscope demonstrations, and challenging microscope electives. The Mohs technician program will feature hands-on training in Mohs laboratory techniques and incorporate important safety and regulatory guidelines and updates. A high faculty-to-student ratio helps ensure rapid skill development and advancement, and allows for discussion of critical troubleshooting techniques relative to tissue processing and slide preparation.

AMA PRA Category 1 Credit Available

Annual Clinical Symposium – Dermatologic Surgery: Focus on Skin Cancer

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

Memorial Day Weekend, May 22-25, 2014
Top experts in the field will provide updates on a wide range of dermatologic surgery and Mohs surgery topics. Interactive forums and panels will discuss appropriate repair strategies for a variety of surgical wounds and innovative approaches to melanoma treatment. Both Mohs and non-Mohs cases will be featured in the microscope laboratory. Mohs support personnel accompanying physicians to the meeting will participate in a standalone session dedicated to important technical topics and updates, discussion of special advanced Mohs laboratory techniques, and sharing of patient care concerns encountered on a regular basis in their work.

AMA PRA Category 1 Credit Available

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  
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<td>Total Available Space</td>
<td>19,219 RSF</td>
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</tbody>
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Ann Arbor Dermatology is looking for a career oriented, conscientious, well-trained dermatologist to join a busy, growing practice. This position offers an opportunity to build a comprehensive practice that encompasses all aspects of dermatology including Mohs surgery and cosmetic work with a highly competitive salary plus bonuses, full benefits and early partnership. For more information please contact A. Craig Cattell, M.D. by phone (734) 996-8757, fax (734) 996-8767, or email: a2derm@aol.com.

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Central Florida Dermatology and Skin Cancer Center (CFD) is seeking a BC/BE Dermatologist and/or Derm-trained Dermatopathologist, interested in joining in 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 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 Don Lackey at (863) 292-2147 ext. 7, or email CV to Daniel@centralfdermology.com. Visit us on the web at www.centralfdermology.com

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 and substantial interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

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

We are seeking a part or full time Dermatologist to join our group of ten Board Certified Dermatologists in a professionally run practice with Dermatopathology, Mohs, Medical Aesthetics, and consulting facial plastic surgeon. This opportunity would allow a highly qualified dermatologist to practice with excellent support staff in a collegial practice in New Hampshire with competitive salary, benefits and practice ownership. For more information, please contact: Glenn Smith, MHA, Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com. www.apderm.com

SOUTHERN NEW JERSEY

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f. Total Free Distribution (Sum of 15d and 15e) 720 750
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CAMP DISCOVERY CELEBRATES 20TH ANNIVERSARY

The Academy’s Camp Discovery program, a summer camp for children with skin conditions, hosted its 20th annual program this summer. Campers and volunteer counselors and medical staff gathered for six different camps at five locations: Hebron, Conn., Crosslake, Minn., Millville, Pa., Burton, Texas, and Carnation, Wash. The resulting experience, documented below, is one that the children who camped and the adults who watched over them will cherish. To learn more or make a donation to support Camp Discovery, visit www.campdiscovery.org or www.AADdevelopment.org/SustainingFund.html. – RICHARD NELSON
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