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DEAR READERS,

Life has always been full of awkward changes.

T
take, for instance, what happened in 1752 in the British Empire. The King decided that it was time to start using the Gregorian calendar in place of the Julian one, now 11 days out of sync with the Earth’s place in the heavens. Up until that point politics between the Protestants and the Catholic Church had kept the Brits attached to the Julian calendar. The change in calendar meant that in 1752 the date of Sept. 2 was immediately followed by the 14th. Riots broke out as the peasants protested, thinking that the monarchy had deprived them of two weeks of life. Those with property, however, saw it differently — they quickly realized that they would receive the next month’s rent only two weeks after the last payment. They touted the advantages of this adjustment. Always winners and losers when change occurs.

This reminds me of what’s going on in payment reform vis a vis dermatology; this month we’ve provided you with an update. Jack Resneck Jr., MD, sums it up by saying “dermatology has a bull’s-eye on its back.” Clearly the federal government is fearful of the enlarging demographics with the baby boomers approaching the retirement age and is working hard to curtail costs. Why are they focusing on dermatology? While dermatologists make up just 1 percent of all physicians, we are responsible for 3.5 percent of all Medicare expenditures. On average 76 percent of our income comes from our procedures. The AADA is doing all it can to impress upon the RUC, Congress, and other governmental agencies that we should not weather the brunt of this storm.

Hopefully, at this moves forward we’ll feel less like the peasants of 1752, and more like the ruling classes.

If Mohs surgery is a part of your practice, then be sure to read our coding column. Rules for billing of biopsies and frozen sections when doing Mohs are clearly laid out. Be sure to take note of the requirement that only the physician doing the surgery can perform these services. As more of us utilize mid-level providers, it is critical to be aware of these rulings.

Kids with melanoma...the only thing worse than making this diagnosis would be missing it. Our Acta Eruditorum column on new diagnostic criteria is crucial reading for everyone. ABCD apply, but not as we know them. Read about the alternative pneumonic device taught to us by our own Kelly Cordoro, MD:

\[
\begin{align*}
A &= \text{Amelanotic} \\
B &= \text{Bleeding, Bump} \\
C &= \text{Color uniformity} \\
D &= \text{De novo, any Diameter}
\end{align*}
\]

We all will want to commit this to memory so that we improve our detection of these dread malignancies in children.

I guess things are always changing...hopefully for the better with improvements in our diagnostic accuracy and in our calendars. Hope you each had a great summer, and by now have your children plugged back into school. With four of mine in either college or graduate school, I am glad to see them all settled and their tuition bills paid. Now if we could just work on change when it comes to tuition bills.

Enjoy your reading.

ABBY S. VAN VOORHEES, MD, PHYSICIAN EDITOR
“An overall environment of concern about escalating health care costs is creating this squeeze on dermatology reimbursement.”

features

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BY ALEXANDER MILLER, MD

Documenting Mohs surgery

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

You have just completed a three-stage Mohs surgical excision of a biopsy-proven recurrent morpheaform basal cell carcinoma located on a Medicare patient’s nose. You have documented a need for Mohs surgery based upon tumor location, histology, and recurrence, and you have specified in the patient’s record that clear margins were achieved after three stages of excision. Having measured and recorded the size of the surgical defect, you then confidently continue on to a reconstruction. Is your Mohs surgical documentation sufficiently complete to withstand a rigorous Medicare audit?

Medicare contractors’ Mohs surgery Local Coverage Determinations (LCDs) vary in their wording. With varying amounts of detail, most require that the following information be documented in the operative report:

1. Qualifying criteria for Mohs surgery (why Mohs surgery was chosen as the appropriate treatment).
2. Who did the Mohs surgery; that is, that the physician was both the surgeon and pathologist.
3. A description of the histology of the excised tumor. (This is currently required only by Palmetto and Noridian.)

Note that some Medicare Mohs LCDs include the following sentence relating to chart documentation:

“When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.” This should serve as an incentive for thorough documentation.

A 2013 CMS Medicare Learning Network Matters (MLN Matters®) article titled “Guidance to Reduce Mohs Surgery Reimbursement Issues” expands upon the language of some Mohs LCDs by specifying exact physical and documentation requirements for Mohs surgery. The publication provides the following documentation guidance and requirements:

1. The medical record should show that Mohs was chosen on the basis of any of the following:
   a. “Complexity” of the lesion: as in, poorly defined borders, suspected deep invasion, recurrence, prior irradiation
   b. Lesion size or location
   c. Maximum conservation of healthy tissue

   Only accepted diagnoses and indications, as listed in individual LCDs, will be considered for reimbursement.

2. Qualifications and Limitations of Coverage:
   a. The person performing the Mohs surgery must be a physician: MD or DO
   b. The physician must be skilled and trained in Mohs surgery and pathology interpretation
   c. The physician does both the surgery and the specimen interpretation

   (Significantly, an Office of the Inspector General (OIG) 2009 publication titled “Prevalence and Qualifications of Nonphysicians who Performed Medicare Physician Services,” which polled 250 physicians, found instances of unqualified medical assistants performing Mohs surgical excisions. Beyond the questions of qualifications and the legality of having medical assistants doing surgery is the fact that Medicare specifically directs that only physicians must do Mohs surgery on Medicare patients. The entire OIG report may be perused at https://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf.)

3. Operative documentation should note:
   a. Evidence that the same physician acted as the surgeon and pathologist
   b. Location, number, and size of the lesions
   c. Number of stages performed
   d. Number of specimens per stage

4. Histology documentation must include:
   a. First stage:
      i. Depth of invasion
      ii. Pathological pattern of the tumor
      iii. Cell morphology
      iv. If present, note perineural invasion or scar tissue

   b. Subsequent stages:
      i. If tumor characteristics are the same as in the first stage, note this fact only
      ii. If tumor characteristics are different from the first stage, describe the differences
Mohs surgery is done:

- Lesions biopsied on the same day as Mohs surgery. You bill:
  - 11100-59 for the biopsy;
  - 88331-59 for the frozen section; and
  - 17311 and 17312 for the Mohs surgery.

**Answer: Correct.** Since no prior biopsy has been done, a preoperative biopsy is both medically appropriate and Medicare reimbursable. The biopsy and the frozen section tissue processing with interpretation are billed with a 59 modifier in order to distinguish them from the Mohs surgery. While a permanent section may be required for the biopsy and should be able to withstand an audit, a permanent section for the last stage of Mohs should only be ordered for a specific lesion and may raise an audit flag.

**Example 2:** You have a busy two-Mohs-surgeon practice. You excise a squamous cell carcinoma from an ear with two stages of Mohs surgery. As after each excision stage you were occupied with a reconstruction procedure on another patient, your colleague Mohs surgeon read out your patient’s slides.

You then bill 17311 and 17312 for the Mohs surgery.

**Answer: Incorrect.** Although your colleague is a Mohs surgeon, you yourself did not both personally excise your patient’s tissue and perform the histopathologic interpretation of that tissue. Consequently, since the same person did not act as both the surgeon and the pathologist, Mohs surgery may not be billed.

**Example 3:** You schedule multiple Mohs surgeries in the morning and, for the sake of moving your elderly patients along, have your trained physician assistant excise Mohs layers on select patients. You then do the histopathology slide interpretation and bill for the Mohs surgeries with the appropriate 173xx series of codes.

**Answer: Incorrect.** Medicare guidelines specify that both the excision and the histopathology interpretation must be done by a physician MD or DO. dw
Telehealth legislation gains momentum

STATE NEWS ROUNDUP

With the pool of insured patients set to grow tremendously while the dermatology workforce holds steady, dermatologists are increasingly looking to innovative new models of providing care. Telemedicine has the potential to expand dermatologic care in underserved areas, but for that to happen, dermatologists and their patients must successfully advocate for reimbursement for the services. A number of bills have passed in 2013, bringing the idea of nationwide telemedicine services for dermatology patients closer to reality.

- Arizona SB 1353, signed into law May 23 by Gov. Jan Brewer in a public ceremony, mandates that private insurers cover telemedicine services in rural areas of the state beginning in 2015. Montana’s SB 270, signed into law April 5, and New Mexico’s SB 69, signed April 2, provide similar mandates for patients in those states.
- Colorado SB 180, signed into law June 5, provides recognition of telemedicine as a permitted method of delivering consultative services for the practice of occupational therapy.
- Illinois HB 2996 also allows for telemedicine delivery of care for occupational therapy. It has passed both chambers and has been sent to Gov. Pat Quinn.
- Indiana’s legislature passed SB 554 to provide Medicaid coverage of telemedicine for rural centers, home health care, and community mental health centers. Gov. Daniels signed it into law.
- Maryland’s SB 496, signed into law May 2, mandates coverage for telemedicine for both private insurers and Medicaid. Mississippi’s SB 2209, signed into law April 1, provides a similar mandate.
- In Missouri, advanced practice registered nurses are allowed to practice via telemedicine in rural areas after the passage of HB 936, signed into law July 8.
- Nebraska’s LB 556 allows for Medicaid coverage of child behavioral services via live interactive telemedicine.
- Oklahoma’s HB 2089, signed into law May 10, repeals informed consent for telemedicine, and HB 1235 allows the state’s Osteopathic Medical Board to issue telemedicine licenses.
- Vermont’s H 272 and S 88, which have been signed into law, will focus on a pilot program that studies the effects of telemedicine when delivered outside of a health care facility.

NEW TANNING LAWS ON THE WAY

As dermatologists continue to spread the messages of skin cancer awareness and proper skin care, legislative activity continues to support bans for minors’ use of harmful tanning beds.

- Connecticut SB 872 prohibits minors under 17 from indoor tanning. Gov. Daniel Malloy signed the bill into law on June 5, and it will go into effect Oct. 1.
- Nevada SB 267, which prohibits minors under 18 from tanning, went into effect July 1.
- Oregon HB 2896, which prohibits tanning bed use by those under 18 without a physician’s prescription, was signed into law and will take effect on Jan. 1, 2014.
- Texas SB 329, which includes a similar prohibition, became law without Gov. Rick Perry’s signature. The law takes effect on Sept. 1. - JOHN CARRUTHERS
Clinically ambiguous PSLs pose a unique diagnostic challenge. Even with years of clinical experience, subjective impressions sometimes don’t provide enough information for a clear biopsy decision. MelaFind® gives you objective data, for a different perspective on clinically ambiguous PSLs and the most curable melanomas.

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MelaFind® is intended to be used when a dermatologist chooses to obtain additional information for a decision to biopsy, but MelaFind® should NOT be used to confirm a clinical diagnosis of melanoma. As with all tools to provide additional information during skin exams, there is a risk that melanomas will be missed and benign moles will be biopsied.

MelaFind® is indicated for use on clinically atypical cutaneous pigmented skin lesions with a diameter between 2mm and 22mm that are accessible by MelaFind®, sufficiently pigmented (i.e., not for use on non-pigmented or skin-colored lesions), that do not contain a scar or fibrosis consistent with previous trauma, where the skin is intact (i.e., non-ulcerated, non-bleeding lesions), that are more than 1cm away from the eye, do not contain foreign matter, and are not on special anatomic sites (i.e., not for use on acral, palmar, plantar, mucosal, or subungual areas).
Study suggests revised ABCD criteria for pediatric melanoma

In this month’s Acta Eruditorum column, Physician Editor Abby S. Van Voorhees, MD, talks with Kelly M. Cordoro, MD, about her recent Journal of the American Academy of Dermatology article, “Pediatric melanoma: Results of a large cohort study and proposal for modified ABCD detection criteria for children.”

Q&A

Dr. Van Voorhees: Thankfully, melanomas in children are fairly rare. They are also very challenging for many of us to diagnose. What do you feel makes this diagnosis so difficult for the clinician? Is it just a low index of suspicion? Do they present in an atypical way?

Dr. Cordoro: Melanomas in children can be difficult to diagnose for several reasons, a couple of which you alluded to, such as a low index of suspicion for skin cancer in children as well as pediatric melanoma’s propensity to present atypically. Age plays a considerable role on all accounts — the younger a child is, the less suspicious we tend to be. Low index of suspicion together with presenting features distinct from those we see in adult melanomas combine forces to make diagnosis challenging. Pre-pubertal children in particular frequently present with melanomas that do not fall in line with conventional clinical features as described by the acronym ABCD — Asymmetry, Border irregularity, Color variegation, and Diameter. Adding to the confusion is the resemblance of amelanotic melanomas, a common clinical subtype in young children, to benign lesions such as pyogenic granulomas and warts.

Dr. Van Voorhees: Do you feel that the diagnosis of melanoma in children is often delayed as a consequence?

Dr. Cordoro: Yes! The atypical clinical features and low index of suspicion contribute to diagnostic delays. Melanomas in children are often treated as warts or pyogenic granulomas, or observed for long periods of time, before the persistence of the lesion or evolution prompts a biopsy. Even then, microscopically ambiguous features, features that do not conform to traditional adult melanoma histopathologic subtypes, or confusion with benign lesions such as Spitz nevi may further delay the diagnosis.

Dr. Van Voorhees: Before your study what did we know about childhood melanomas? Did we have inkling that their clinical features were somewhat different than adult melanomas?
DR. CORDORO: The clinical and histopathologic features of childhood melanoma, especially in pre-pubertal patients, are understudied, and as a result, are poorly characterized. Large cancer databases like SEER and NCDB lack adequate clinical details to determine and describe differences in the clinical presentations of melanoma in pre-pubertal and post-pubertal patients. Several well-done but smaller clinical series have reported the frequent observation that melanomas in young children are more often amelanotic, nodular, and histologically thicker at diagnosis than melanomas in adults. We knew from these previous publications and our own clinical experience that melanomas arising in pre-pubertal patients in particular often fail to conform to traditional ABCDs and are misdiagnosed or diagnosed after a long delay. In general, melanomas arising in teenagers and young adults more often present more typically and in keeping with adult characteristics. In general, though, unless one is very familiar with the small amount of literature on this, I do not think that it is common knowledge among general dermatologists just how common atypical presentations in younger children might be. As a pediatric dermatologist who formerly practiced adult dermatology, I began seriously thinking about this issue during my pediatric derm fellowship in 2007, when I realized that the literature had significant gaps in this area — thus the study.

DR. VAN VOORHEES: Tell us about your study and its findings. What have we now learned?

DR. CORDORO: The goals of this study were to describe the clinical and histopathological features and outcomes of all cutaneous melanomas diagnosed in children at the University of California, San Francisco, and analyze whether conventional ABCDE criteria (Asymmetry, Border irregularity, Color variegation, Diameter > 6 mm, and Evolution) were adequate to clinically detect them. We also sought to determine whether younger pre-pubertal children present differently from older children and which clinical and histologic variables are associated with metastasis.

Our study highlights key differences in clinical presentation, microscopic features, stage, and outcomes between children aged 0 to 10 years (pre-pubertal) and aged 11 to 19 years. Previous series have identified atypical presentations of pediatric melanoma; however, most lack adequate clinical details and statistical power to draw meaningful conclusions. Our cohort includes 19 pre-pubertal children, representing one of the largest series reporting detailed clinical and histopathological features of melanoma in this age group, and this is clinically very important.

Our study taught us that childhood melanoma often presents unconventionally and current clinical detection parameters in widespread use (ABCD) fail to identify a significant subset of childhood melanomas. Thus, conventional ABCD criteria are inadequate in children. The majority of younger children in our study had melanomas that, in contrast to the traditional ABCD features, presented with amelanosis, symmetry, regular borders, uniform color, and diameters less than 6 mm. The melanomas in older children were evenly split between conventional ABCD (more adult features) and unconventional features. The most sensitive indicator of melanoma in children was a lesion that evolved, thus, the E for Evolution should be universally applicable in all populations, independent of age.

DR. VAN VOORHEES: Are the risk factors for melanoma the same as in adults or are they skewed to congenital nevi tumors?

DR. CORDORO: Some risks are the same, and some are unique to children. The presence of a large congenital melanocytic nevus does present a heightened individual risk to that particular patient, but does not contribute very significantly to overall melanoma risk in children in general. Other risks in children include the presence of numerous (50 or more) melanocytic nevi, dysplastic nevus syndrome, sun-sensitive phenotype, family history of melanoma, and DNA repair defects such as xeroderma pigmentosum. Children who are iatrogenically or genetically immunosuppressed, have received excessive ultraviolet radiation, or have a history of malignancy resulting in radiation and/or immunosuppressive therapies are also at greater risk.

Interestingly, in younger children, darker Fitzpatrick skin types are overrepresented; the presence of dark-skinned, non-Caucasian subjects in younger pediatric cohorts suggests that childhood melanoma differs in unique ways from that occurring in adults. Our study confirmed the importance of family history of melanoma in children of all ages and the contribution of numerous acquired melanocytic nevi and personal history of more than three sunburns to risk of melanoma in older children, suggesting the impact of genetic predisposition in younger children and the larger influence of environmental exposures for melanoma development in older children. Only a minority (11 percent) of our cohort developed melanoma in the context of large congenital melanocytic nevi (LCMN), immunosuppression, dysplastic nevus syndrome, or history of cancer.

Importantly, of 322 pediatric patients with melanoma comprising eight single-institution studies, only 22 percent had a predisposing risk factor, underscoring the need for awareness even in the absence of known risk factors.

DR. VAN VOORHEES: Does the histology seem the same in children and adults?

DR. CORDORO: No, especially in the younger children. Pathologically, pediatric melanomas show distinct differences from conventional adult melanoma. Our group includes few cases of melanoma in situ or superficial spreading melanoma. Rather, most presented with nodular, Spitzoid, or unclassifiable melanomas.

These pathologic differences seem to parallel the non-(conventional) ABCD morphology observed clinically.

Interestingly, the majority of...
melanomas eventuating in death and nearly half (44 percent) overall were not classifiable by experienced dermatopathologists using conventional adult subtypes (e.g., superficial spreading, nodular, acral lentiginous). These categories provide an inadequate structure for the classification of pediatric melanomas. Additional studies are warranted to determine if such melanomas in children can be better stratified by molecular analysis. Sadly, the inapplicability of adult melanoma subtypes to most childhood melanomas also contributes to delayed diagnosis.

DR. VAN VOORHEES: Is there a difference in the histology of children depending on their age of onset?

DR. CORDORO: Yes. Histopathological subtypes in the study population differed significantly between the younger and older groups. Unclassified/ambiguous and Spitzoid melanomas comprised 47 percent of lesions in pre-pubertal children while unclassified melanomas represented the majority in older children. Conventional adult melanoma subtypes such as acral, superficial spreading, and nodular were more prevalent in older children whereas only the nodular subtype was represented in pre-pubertal children.

DR. VAN VOORHEES: Is there a difference in risk of metastasis or in survivability?

DR. CORDORO: Prognostic factors in adult melanoma are well established but are less clear in children. The effect of some factors, such as tumor thickness, may depend on age or pubertal status. In our study, Breslow thickness predicted metastasis but not death, likely as a result of inadequate power to detect an association because of the small number of deaths. Survival estimates for children of different ages vary depending on the source and it remains unclear if outcomes differ significantly from adults. Similar to previous studies, we observed thicker primary lesions and more frequent sentinel lymph node (SLN) metastases in young children compared with adults. To date, the prognostic impact of SLN positivity in patients with pediatric melanoma or ambiguous lesions is unclear, and additional studies from larger cohorts of patients will be required to definitively address this question.

Our cohort revealed more histologically aggressive features (ulceration, mitosis) in younger compared with older children and 92 percent of younger kids presented with stage IIA or higher versus less than half in stage IIA or higher in the older group. Paradoxically, only one death occurred in the younger group, and it was in the context of a LCMN, supporting a less aggressive biologic behavior of Spitzoid and other melanomas occurring in young children while older, presumably post-pubertal, children’s tumors seem to behave more similarly to adult melanoma.

In scrutinizing the features of the 10 patients who died, several features stand out. Diagnosis was delayed for more than one year in 60 percent of patients and 60 percent of patients had at least one risk factor for melanoma. Six of 10 who died had SLN biopsy at diagnosis, and only two specimens revealed positive findings. All three patients with melanoma arising in LCMN died — one infant and two teenagers — with widespread metastases and death within eight months from diagnosis. Interestingly, one of the melanomas arising from a LCMN was amelanotic. In contrast to an emphasis on cutaneous melanoma risk in LCMN in the first decade, these data underscore that melanoma can arise at any age in this setting.

Other risk factors such as prior malignancy, immunocompromise, and dysplastic nevus syndrome may carry increased mortality risk compared with melanomas in children without such risk factors. In our study, seven of 10 melanomas leading to death were clinically amelanotic, raising the unanswered question of whether this subtype carries a more dismal prognosis.

DR. VAN VOORHEES: What would you recommend to the practicing dermatologist who is seeing children in his or her office for evaluation of moles — is there any guidance that you’d like to provide?

DR. CORDORO: It is clear that conventional ABCD criteria for clinical detection of melanoma are not fully adequate for children. Overall, the conventional ABCD criteria captured less than half of the clinical characteristics of melanoma in the younger children, and less than 60 percent of those observed in the older children. The criterion of evolution was universally valuable, capturing nearly 100 percent of the entire cohort. Based on these findings, we propose the following criteria for children be considered when doing skin checks in children:

A = Amelanotic
B = Bleeding, Bump
C = Color uniformity
D = De novo, any Diameter

The goal of the modified ABCD criteria is to raise awareness of the alternate presentations of melanoma in children, not to provide absolute diagnostic criteria or to reject the original ABCDEs — the features of which may also be found in childhood melanomas of all ages. Considering all of these characteristics may facilitate earlier detection by modifying the overall concept of how melanoma may present in children. When performing “mole checks” in children, maintain a keen suspicion of any new, persistent (beyond several weeks), or recently changed lump or bump, pigmented or not, with or without asymmetry, irregular border, color variegation, or size greater than 6mm. Children with suspicious lesions even without well-recognized risk factors should be treated with an elevated baseline level of awareness.

Because benign and transient inflammatory lesions such as insect bite reactions and folliculitis are common in children, observing suspicious amelanotic or papulonodular lesions for several weeks before biopsy is appropriate. dw
I have had psoriasis for 20 years now. I have tried all steroids, creams and lotions and even tar baths. Nothing has cleared my psoriasis like Mushatts. R.B.

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

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

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Let’s get ethical

Let’s face it — no one wants to report a colleague for an ethical violation. But the American Academy of Dermatology’s Code of Medical Ethics for Dermatologists imposes an affirmative obligation on its members to do precisely that in certain circumstances, such as false expert witness testimony, self-medicating, or inappropriate behavior with patients, their staff, or Academy staff. Filing such a report can have severe repercussions for the accused member, but can also create potential legal risks and other problems for the complainant. Therefore, it is incumbent upon Academy members to be familiar with their obligations under the Code and the procedures for filing and adjudicating complaints, both of which are available on the Academy’s website at www.aad.org/Forms/Policies/ar.aspx.

OBLIGATION TO REPORT
The Code sets forth the dermatologist’s obligation to report a colleague for an ethical violation or a violation of the Academy’s bylaws or other policies as follows:

Academy members are expected to report knowledge of violations of the Bylaws, Code of Ethics, or other Administrative Regulations or Board-approved policies to the Academy. When a member is convinced that another member is violating the Bylaws, Code of Ethics, other Administrative Regulations, or Board-approved policies, the member should send a confidential written communication to the Academy’s secretary-treasurer or executive director. The information so submitted will then be further investigated and processed according to the provisions of the Bylaws and Administrative Regulations.

The Code also encourages dermatologists to work with their peers to prevent or stop unethical or illegal activity and/or to report such misconduct to the proper legal authorities.
PROCEDURES FOR FILING AND ADJUDICATING COMPLAINTS

The Academy’s Administrative Regulation on Judicial Panel – Disciplinary Procedures outlines in great detail the steps involved in initiating and adjudicating ethics complaints or other disciplinary actions. The primary reason for such detail is to protect the due process rights of Academy members accused of misconduct. Such complaints may only be filed by an Academy member or the Ethics Committee itself. The complaint must be in writing and submitted to the Academy executive director. It must specify the basis for the complaint and point to the specific provisions of the Code or Academy bylaws that has been violated, or other basis for disciplinary action.

The executive director shares the complaint with the chair of the Ethics Committee, the president, the secretary-treasurer, and legal counsel. The Ethics Committee chair and the secretary-treasurer, in consultation with legal counsel, will review the complaint and determine whether it meets the criteria set forth in the Disciplinary Procedures. Specifically, the complaint must state facts that if proven to be true would provide a basis for disciplinary action. If the complaint does not meet this test, or it involves a matter that is the subject of pending litigation, the complaint will be dismissed.

If the complaint survives this review, the complainant will be notified and given the chance to provide more information. The notice will also state that the complaint (including the name of the complainant) will be shared with the respondent, but otherwise must be kept confidential until there is a final resolution. The notice will inform the complainant that s/he has the right to withdraw the complaint, and if s/he does so, the Ethics Committee may exercise its discretion to initiate a complaint against the respondent on its own, and will keep the complainant’s identity anonymous if doing so would not violate the respondent’s due process rights.

The respondent then has the opportunity to submit a response to the complaint, which will be shared with the Ethics Committee and the complainant. The Ethics Committee reviews all of the submissions by the parties and meets to decide whether the complaint states a valid ethics claim — i.e., whether the allegations, if proven to be true, would constitute a violation of the Academy’s Bylaws or Code of Ethics, or represent other conduct justifying disciplinary action. If the Committee finds that complaint fails this test, it will dismiss the complaint. If it finds that the complaint does state a valid ethics claim (if the facts are proven to be true), the matter will be referred to the Academy’s Judicial Panel. At this point, the respondent will be given the opportunity for a hearing before the Judicial Panel. If the respondent does not request a hearing, the Judicial Panel will move forward based on the written submissions. If a hearing is requested, the Judicial Panel will hold the hearing in accordance with the procedures set forth in the Administrative Regulations and make its determination based on the hearing testimony and the documents.

Either way, the Judicial Panel makes a recommendation to the Board as to whether the complaint should be dismissed or provides a basis for disciplinary action. If the Judicial Panel decides to exonerate the respondent, that determination is final. If the Panel decides that disciplinary action is warranted, that determination is passed on to the Board in the form of a recommendation, which must also specify which of the available disciplinary actions should be taken by the Board — i.e., censure/admonition, probation, suspension, or termination of membership.

If the Panel recommends disciplinary action, the respondent will be given a chance to appear before the Board of Directors in an informal hearing. After reviewing the submissions and testimony, the Board of Directors may accept, reject, or modify the recommendation(s) of the Judicial Panel, and an affirmative vote of at least two-thirds of the members of the Board of Directors present at the hearing is required to approve any disciplinary action. The Board must also decide which sanction to impose. A decision to take disciplinary action must be based on a reasonable belief that the action is warranted by the facts and circumstances presented in the case.

The Board’s decision is final, and notice of the decision is sent to the respondent and the complainant within 30 days, including a statement of reasons for the decision. The Academy will report the decision to the National Practitioner’s Data Bank and the appropriate state medical board if the underlying conduct is associated with patient treatment and welfare. The information may also be reported to the American Board of Dermatology or local dermatology societies if the circumstances justify doing so. Otherwise, the Board’s decision remains confidential.

The Academy has also developed an abbreviated process for handling complaints against members based on a state medical board taking disciplinary action against that member’s license, if the member voluntarily surrenders his/her license during the pendency of a proposed disciplinary action against the member, or if the member is indicted or convicted of a felony.

PROTECTIONS FOR COMPLAINANTS

While there is always a risk that a respondent will sue a complainant for defamation or under some other tort theory, the Academy’s disciplinary process is designed to
ensure that it is eligible for immunity provided by the Health Care Quality Improvement Act for organizations engaged in bona fide peer review activities and for those who report in good faith to such organizations. Illinois, where the Academy is headquartered, has also provided statutory protection for individuals who report to peer review organizations within the state through the Illinois Medical Studies Act. Many other states have provided similar immunity from suit for peer review participants and reporters. Although the protections provided by these statutes are not guaranteed, they should provide some comfort to members about the legal risk of reporting ethics violations to the Academy.

**TIPS ON FILING ETHICS COMPLAINTS**

Academy members considering filing a complaint against another member should go through the following checklist:

1. A complaint may only be filed by a member against a member. Non-members may not file complaints, and the Academy does not have jurisdiction to take disciplinary action against non-members.
2. The conduct must violate a specific provision or provisions of the Academy’s Code of Ethics, bylaws, or other policies.
3. The complaint must submit all the relevant information and documentation, and all patient identifiers should be redacted (removed).
4. The matter must not be the subject of pending litigation.
5. The complainant may ask to remain anonymous, but the Ethics Committee may or may not pursue the complaint on its own initiative; it will only pursue the complaint without identifying the complainant if doing so will not violate the due process rights of the respondent.
6. The matter must be kept confidential except for official reports submitted by the Academy to the National Practitioner’s Data Bank, state medical boards, and others.

Filing an ethics complaint against a fellow Academy member is serious business. But it is also an ethical obligation. Those considering filing a complaint should carefully review the Academy’s Administrative Regulations on Code of Ethics and Judicial Panel – Disciplinary Procedures before taking this step. dw
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SHIFTING SANDS

Changing reimbursement landscape has dermatologists wondering about the future
Accountable care organizations. Value-based payments. Fixed payment models. Outcome-based reimbursement. These phrases and others are swirling around the national conversation relative to health care, but they all point back to one phrase that gives everyone involved pause: Unsustainable spending trajectory.

"Health care spending growth is facing pushback from multiple stakeholders, even as the rates of increase have moderated somewhat in the last year or two," said Jack S. Resneck Jr., MD, advisor to the American Academy of Dermatology Association’s Council on Government Affairs, Health Policy, and Practice and associate professor and vice chair of dermatology at the University of California San Francisco School of Medicine. "At a time when the federal deficit is getting substantial attention, Medicare and Medicaid are projected to be the primary drivers of increased government spending in decades to come." But the pressure isn’t just coming from the government, Dr. Resneck added. "On the private side, insurers are facing increasingly stiff pushback from employers who are unwilling to sustain continued year-over-year increases in premiums that dwarf the rate of inflation." >>
Indeed, rising premiums are a threat to American competitiveness in a global economy, according to Rep. Jim Matheson (D-Utah), former co-chair of the Blue Dog Coalition and a member of the House Committee on Energy and Commerce and its Subcommittee on Health. “The fact that we spend about 50 percent more per person on health care than the next highest-spending country in the world creates a competitive disadvantage for us with the rest of the world in terms of how we perform in the business sector,” he said.

Add to that the fact that health care spending is the primary driver for increased spending both at the federal level and in the states, where Medicaid is the fastest-growing component of almost every budget, and you find a broad consensus that something has to be done to control spending, Rep. Matheson said.

“While the causes of rising health care costs are complex, the resistance against continued expansion in health spending is solidifying, and both government and private purchasers and insurers are looking to the medical community to identify and seek consensus on how slower growth can be accomplished,” Dr. Resneck said. As opportunities for savings are sought, he believes that dermatology will be targeted in response to growing spending driven by the skin cancer epidemic and by the availability of new treatments for medical dermatology conditions.

**CHANGES AT THE RUC**

This is an issue that sometimes plays out in the confines of the AMA Relative Value Update Committee, or RUC, according to Brett M. Coldiron, MD, the AADA’s president-elect and one of its representatives at the RUC. (The RUC makes recommendations regarding the relative values of CPT codes, which are translated into relative value units, or RVUs, when the Centers for Medicare and Medicaid Services [CMS] publishes the Medicare fee schedule each year.) The total amount of Medicare reimbursement to physicians is set by statute; the RVUs divide this limited pie. For a variety of reasons, including the addition of more primary care representatives to the RUC, he said, “There’s pressure to reduce the reimbursement for procedures in order to increase reimbursement for primary care.” This, in turn, “is a stressor on dermatology reimbursement because, while many people don’t realize it, procedures done in the office make up 76 percent of dermatologists’ income.”

But of late, the battles within the confines of the RUC have taken a back seat to the way CMS handles the recommendations RUC sends it.

“CMS is trying to show its independence,” Daniel M. Siegel, MD, the AADA’s immediate past president and one of its representatives at the RUC, said. “For the longest time, CMS took about 90 percent of RUC recommendations. In the past year they seem to have started making some arbitrary cuts.” The cuts, Dr. Coldiron added, are made without any explanation. “That’s not good enough; if they’re going to reject a valuation after these huge surveys were done, with hours or days of arguing at the RUC and really honing the practice expense and work that goes into a procedure, they should give more justification than ‘just because,’” he said. Dr. Coldiron suggested that direct-to-CMS lobbying may be necessary alongside the AADA’s continued efforts at the RUC.

Still, in this environment, some cuts to codes that dermatologists bill frequently may be inevitable.

**MORE SCRUTINITY OF REIMBURSEMENT**

The new attitude toward RUC recommendations at CMS is part of a larger shift toward scrutiny, according to Barbara Greenan, senior director of government affairs for the AADA.

“CMS is getting an enormous amount of pressure from the Medicare Payment Advisory Committee (MedPAC) and Congress to much more heavily scrutinize the RUC recommendations and look at the process of how the RVUs are arrived at and how the practice expenses are calculated,” Greenan said. “That’s why you see the Urban Institute and the RAND Corporation contracted to do studies on how the RVUs are established, asking how accurate the time being reported is, especially on the work side, and looking at whether doctors who are being surveyed are being honest — or if they are driven by outside factors as they come to understand how the surveys work.”

The RAND project, set to last two years, will build a model to validate the work RVUs, a requirement established in the Patient Protection and Affordable Care Act (ACA). The project overview hints at the rationale for this, noting that “systematic over- or underpricing of procedures furnished by particular specialties can distort overall compensation levels and
affect the specialty choices made by new physicians.”

Meanwhile, the Urban Institute will use a variety of data sources to develop alternative estimates of service-level time and compare the results with the time values that appear in the fee schedule. While the project will focus on only 100 services, the results will be reviewed for their potential applicability across similar services and have the potential to refine valuations across the fee schedule.

While it’s tempting to look for someone to blame, the reason for the high degree of scrutiny isn’t a particular entity, whether CMS or MedPAC or Congress, Greenan said. “It’s an overall environment of concern about escalating health care costs that is creating this squeeze on dermatology reimbursement.”

**THE REAL PROBLEM: DEMOGRAPHICS**

He may not agree with the way the ACA seeks to address the problem, but Rep. Tom Price, MD (R-Ga.), vice chair of the House Budget Committee, said that fundamental reform is necessary to address costs in health care (and has introduced a Republican version of such reform, the Empowering Patients First Act, in each Congress since the ACA was introduced). “The increasing costs are driven not just by increasing technology and the increasing costs of health care itself, but also to a larger degree by the changing demographics of our society,” Dr. Price said. “There are 10,000 Baby Boomers reaching retirement age every day. Right now there are 48 million individuals in Medicare; 78 million individuals will be joining it over the next 18 years. For them to be absorbed into the system requires significant changes to control the cost.”

Just what those changes will look like, though, is a sticking point.

Some cost containment could come through reducing overutilization of services, Rep. Matheson said — particularly related to defensive medicine. “We should pursue a broad malpractice reform agenda that creates a safe harbor provision for people in the medical delivery system who operate within a defined standard of care,” he said. “That would go a long way toward reducing unnecessary tests and procedures that are only being done now to prevent a lawsuit.”

Administrative simplification would also cut costs,

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**WHAT DOES THE FUTURE LOOK LIKE?**

No one can predict with certainty what payment models will emerge as the most successful as implementation of the Affordable Care Act continues. But two members of Congress who vigorously opposed the ACA’s passage see other elements of the near future of health care that are currently cloudy becoming clearer if the ACA remains law, including insurance coverage issues and the use of the electronic records.

Regarding insurance coverage, Rep. Larry Bucshon, MD (R-Ind.), a member of the House Committee on Education and the Workforce’s Subcommittee on Health, Employment, Labor, and Pensions, said, “Ultimately you’ll have an expansion of the Medicaid program even in states that haven’t yet agreed to it and I think you will see, more than is predicted, people going into the state or federal exchanges. Employer-provided insurance will devolve as part of the way we pay for health care.” This will accrue significant costs to the federal government, he said, and result in physicians seeing many more patients with insurance plans that pay at the Medicare rate or lower, as he expects plans sold on the exchanges will.

Meanwhile, according to Rep. Tom Price, MD (R-Ga.), vice chair of the House Budget Committee, a change is needed in the way the government addresses electronic health records, but EHR “has a huge role in saving costs in the health care system.” He suggested that rather than judging the meaningful use of systems by physicians, the government should set standards regarding the computer languages the systems should use so they can interoperate successfully. “People are becoming more receptive to the government dictating the language as they hear horror stories of people spending $50,000 on a system that doesn’t talk to the hospital down the street,” he said. Dr. Bucshon questioned whether EHR use would ultimately save the government money, but agreed that “the train has left the station. It’s a better way to record-keep and something that’s necessary.”
he said. “Government policies and regulations that may each have been well-intended when they were implemented should be looked at as a whole and assessed as to whether they are structured in the most efficient way. I suspect they are not.”

Neither of those issues is likely to be addressed quickly, though. In the short term, Dr. Resneck said, members of Congress on both sides of the aisle agree that the sustainable growth rate formula, which annually threatens to slash physician payments (this year’s scheduled cut is 24 percent), has to be repealed. (Efforts to do so garnered headlines in the medical press this summer, but a repeal bill has not yet passed.) “There is, however, equally strong bipartisan agreement that any SGR repeal must be accompanied by a transition to a ‘new payment system’ that rewards value rather than volume,” Dr. Resneck said. Indeed, a report in the New England Journal of Medicine this spring from the National Commission on Physician Payment Reform, under the byline of Republican and former Senate Majority Leader Bill Frist, MD, as well as former Robert Wood Johnson Foundation CEO Steven A. Schroeder, MD, laid out a dozen recommendations for reform, including significant changes to the RUC process, the inclusion of a pay-for-quality component in all contracts, and a move to fixed payments for many episodes of care — under the title “Phasing Out Fee-for-Service Payment” (368:21, available online at www.nejm.org/doi/full/10.1056/NEJMc1302322).

The details of such a phase-out and transition to a new system, if it occurs, would fall to Congress. The problem, Dr. Resneck said, is that “Congress doesn’t know how to create such a system, but both political parties are determined to do so, and are looking to the medical community to design something. They understand that a single model won’t work for all specialties, but they’ve expressed little patience for specialties that are unwilling or unable to define quality and value for themselves.”

DATA DEMANDS

Indeed, Rep. Larry Bucshon, MD (R-Ind.), a member of the House Committee on Education and the Workforce’s Subcommittee on Health, Employment, Labor, and Pensions, said that whether the system is consumer-driven (his preference) or government-run, “ultimately, the combination of price and quality, or value, will be rewarded financially.” The issue, in that eventuality, is where the data comes from. “I want your members to be the ones providing the data on what constitutes quality dermatologic care,” he said. “I don’t want the government or the insurance companies providing their opinions. I want the specialty to do it.” (Dr. Bucshon, a thoracic surgeon, noted that the Society of Thoracic Surgeons maintains a voluntary database regarding quality in his specialty.) “If you have CMS utilizing data on what constitutes quality medical care, you want it to come from you, not Medicare or the insurance companies,” he said.

The AADA is working on the data issue, according to Kathryn Schwarzenberger, MD, who serves as Amonette-Rosenberg Professor and Chair of the University of Tennessee dermatology department and chair of the Academy’s Workgroup on Innovative Payment and Delivery. “We’re aware of the need, in order to justify our piece of the pie, to demonstrate the quality and the cost-effectiveness of the work we provide.” Dermatology, as a specialty, has historically had a paucity of data, she said, in part because of the diversity and nature of the diseases it treats. “But we as a specialty need to have quality and outcomes data. The new paradigm of health care reimbursement will tie reimbursement to documented quality measures and to outcomes, and the Academy is responding.”

The move to quantify could have a huge upside for dermatology, according to Dr. Coldiron. “The scrutiny of health care pricing in the outpatient setting will be wonderful for us,” he said. “Dermatologists are incredibly efficient and cost-effective and we’ve never been recognized for it. Once that’s recognized you’ll discover that we do things so much less expensively than other specialties that we’ll be winners. That’s not something we should be afraid of at all,” he added. “The cost of Mohs surgery in a dermatology practice is a fraction of removing a cancer in a hospital, a fraction of what radiation costs.” The consideration of data that demonstrate this will only benefit dermatologists, he said.

But regardless of where the data come from or what they show, Dr. Price, an orthopedic surgeon, urged caution. “The government’s definition of value will be based on cost, not on the quality of the
services provided to an individual patient,” he said. Still, he said, physicians should be involved in quality improvement efforts; indeed, he argued, they are the only ones who can really understand the kind of quality care that can and should be provided to patients.

TIME TO BE INVOLVED
What should dermatologists do now? “This is not a time for dermatologists to be ostriches,” Dr. Schwarzenberger said. “We can’t put our heads in the sand and hope that business will be the same 10 years from now as it is now. It’s a very important time for all of our colleagues to be active in their local health care environment, whether that’s an academic medical center, a small community, or a big city — they should be really in tune with their local environment, and get involved in things like their county and state medical societies.” No two dermatologists’ experiences will be quite the same, she said; “It may be that under the accountable care model, your experience is entirely different if you’re the only dermatologist in a small community than it will be if you’re one of 100 dermatologists in a big city.”

And the accountable care model, while it has attracted much attention, may not be the one that endures, or the prevailing model in every community, Dr. Resneck added. “Many new payment models are being piloted, and it’s entirely too soon to say which will take root and which will fail,” he said. But, he added, “it’s becoming clear that incentivizing projects to reduce spending and moving control of spending prioritization to local delivery organizations is part of our future. In any of these models, it will be critical for dermatology to be visible at the local and regional level, to participate in care integration, and to demonstrate its value.”

Despite the challenges ahead, Dr. Schwarzenberger remains optimistic about the future. “The way our practices look 10 years from now may not be the same, but we will still be very lucky to be dermatologists.”

DERMATOLOGY’S APPROACH IN A NEW SYSTEM
Robert A. Swerlick, MD, Alicia Leizman Stonecipher Chair of Dermatology at the Emory University School of Medicine and a member of the AADA’s Workgroup on Innovative Payment and Delivery, offers a series of seven assumptions about the changing health care system that he believes require dermatologists to think carefully about their role in it.
1. Our present spending trajectory in health care is unsustainable.
2. Based upon assumption #1, different payment models are desirable to avoid national bankruptcy based upon uncontrolled health care spending.
3. Care of patients with skin disease is an essential element of health care.
4. The ability to deliver health care, including dermatologic care, at higher quality and lower cost to more people is desirable, and these goals should be championed by leadership in dermatology.
5. The continued existence of dermatology as a discrete specialty will depend upon the ability of dermatologists (individually and as members of groups) to demonstrate that we bring value to those who pay for our services, which will include patients and third-party payers. Central to demonstrating value are the abilities described in assumption #4.
6. The question is not if we will need to change but how we will change.
7. There will be winners and losers and perhaps the most important goal should be that patients are winners. Dermatologists can position themselves to be winners if we champion approaches that bring value to patients and put ourselves in a position to demonstrate this in a measurable way.
Better Together

Restoring volume with fillers, combining procedures enhances results
Call it the global approach to facial rejuvenation. After years of attacking the individual lines and wrinkles that many patients loathe, leading cosmetic dermatologists have learned to address their underlying causes with multiple agents and procedures. “Years ago, we just injected the fine lines and wrinkles. We didn’t realize that restoring a youthful look was more about restoring lost volume in other areas of the face,” said Bruce E. Katz, MD, clinical professor of dermatology at the Mount Sinai School of Medicine and director of the Cosmetic Surgery and Laser Clinic at Mount Sinai Medical Center. “That depletion of volume—which results from gradual loss of fat, muscle, and bone—leads to deepening nasolabial folds, marionette lines, and laxity of the jowls. Everything droops because the support structure’s not there anymore. So now we use fillers to restructure the face, to counteract the gravitational changes.”

**BY JAN BOWERS, CONTRIBUTING WRITER**
Fillers approved by the U.S. Food and Drug Administration include hyaluronic acid (Restylane, Perlane, Juvederm, and Belotero, the most recently approved), poly-L-lactic acid (Sculptra), and calcium hydroxyl apatite (Radiesse). Voluma, a hyaluronic acid widely used in Europe, is expected to reach the U.S. market within the next year or two. In addition, a handful of autologous agents provide other options. Dr. Katz said he uses platelet-rich plasma (PRP), already FDA-approved in wound healing, to restore volume and stimulate stem cell growth. “We’ve used it in the tear troughs, and it’s done very well,” he said. “Not only volume, but texture, luminosity, and pigment are all improved.” Kimberly J. Butterwick, MD, a private practitioner in San Diego who co-authored an in-depth look at autologous fat transfer techniques in Facial Plastic Surgery Clinics of North America (15(2007):99-111), said she can “recycle” as much as 30 to 50 cc’s of fat from a liposuction procedure into a patient’s face. “It’s way too expensive to use synthetic filler in that quantity, but we can use as much fat as we want,” she said. “The longevity isn’t entirely predictable, but I’ve seen some patients for whom the fat has stayed in their cheeks for many years.” (One study cited in Dr. Butterwick’s paper reported 55 percent fat loss within six months followed by negligible loss at nine and 12 months.)

**COMBINATIONS THAT WORK**

While a single injection of neurotoxin or filler is still appropriate in many cases, the experts say that a combination of procedures often yields more natural and longer-lasting results. “We call it the four Rs: relaxing the muscles, refilling the face, resurfacing with lasers, and redraping with either facelifts or skintighteners like radiofrequency or ultrasound,” Dr. Butterwick said. The multi-pronged approach “is more natural than just using volumizing to fix everything, or just using toxin. The combinations address all the aspects of aging.”

Thanks to the broad variety of approved agents, a combination treatment may involve two fillers, as opposed to a filler and another procedure. “The more I practice, and the more facial analysis I do, I like to combine the non-hyaluronic acid products with the hyaluronic acid products,” said Joseph F. Sobanko, MD, director of dermatologic surgery education and assistant professor of dermatology at the Hospital of the University of Pennsylvania. “For example, for patients who have deepened pre-jowl sulcus and/or deepened melolabial folds, I’ll often split products. I’ll place calcium hydroxyl apatite in a deeper plane — that particular product has a G’ prime that gives you more of a lift; it’s able to withstand pressures more. But often there are finer rhytids at the oral commissures, and in planes where I don’t feel comfortable injecting the more viscous product. So I’ll overlie the hyaluronic acid more superficially, almost in a tiered or towered pattern. You’re addressing the rhytids in two different ways, and I feel that the results are improved.” For Dr. Butterwick, who said she loves fillers, a common treatment would be “to lift the cheeks and temples with calcium hydroxyl apatite, or a thicker hyaluronic acid, then use a lightweight filler.” The latter may be too soft for lifting, but Dr. Butterwick likes to use it superficially — such as in the tear trough or in fine lines around the mouth — “because it doesn’t cause the Tyndall effect.” Combining a filler with a neurotoxin can have a synergistic effect, say the experts. “There’s not a day goes by that I don’t do polytherapy,” said Seth L. Matarasso, MD, clinical professor of dermatology at the University of California School of Medicine in San Francisco. “Putting two to five units of toxin into the depressor anguli oris reduces the pull of that muscle and lifts the corner of the mouth, so you won’t need as much filler, and it makes your filler last longer.” Dr. Matarasso said he uses toxin-filler combinations “in the glabellar area, the marionette line, and the area around the eye. Putting a hyaluronic acid in the inferior ocular sulcus masks that hyperpigmentation. Then if you take a little bit of toxin at the lateral canthal ridge, you get rid of crow’s feet.” Although he may inject filler and toxin in the same anatomical area in one office visit, “what I will not do is put a filler and toxin into the same syringe, and people have been known to do that.”

Dr. Sobanko agreed, noting that “when toxin diffuses in the wrong place, you can end up with adverse sequelae. To have a syringe with both filler and toxin being injected in what I would consider a non-targeted way can introduce more side effects than if they were injected individually in separate syringes.”

Although readily admitting that toxins and fillers injected at the same time yield synergistic improvement, Dr. Sobanko said that for patients new to cosmetic treatment, he injects the toxin and filler in separate visits five to seven days apart. “That gives
them the ability to see the benefit of each product,” he explained. “I prefer to start them off on a toxin, give them a week or two to see the benefits, and then the rhytid would likely require even less filler, because the muscle has been relaxed, and the filler would likely last longer because that muscular contraction is not expediting the absorption of the filler.”

TARGETING THE GLABELLA

While many dermatologists treat the glabellar crease with a toxin-filler combination, Dr. Sobanko said he does not inject fillers in that location and, in fact, tries to avoid injecting them in the upper third of the face. “Based on the anatomic depth of the vasculature arising in the supratrochlear and supraorbital area, if you place filler in a subcutaneous plane, the risk for tamponading one of those vessels and/or intravascular occlusion is too high, in my mind, and there have been a number of case reports to show that ischemia and necrosis in the forehead is a serious risk. So I avoid it, though others may feel comfortable with it.”

Another potential complication in this area surfaced in a patient of Susan H. Weinkle, MD, assistant clinical professor of dermatology at the University of South Florida. The patient presented with double vision after having her glabellar lines treated with a hyaluronic acid filler and a toxin. When a search of the dermatology literature yielded no clues, Dr. Weinkle consulted her husband, an ophthalmologist, to determine the cause. She learned that when using a filler and toxin together in this area, “you have to be aware that if you fill too far medially and inferiorly, and then inject the toxin too low, the filler and filler in this area, you have to be aware that if you fill too far medially and inferiorly, and then inject the toxin too low, the toxin can diffuse into that orbital rim.”

Success in rejuvenating with fillers depends at least as much on the practitioner as it does on the product, say the experts. For Mary Lupo, MD, clinical professor of dermatology at Tulane University School of Medicine, “it’s not the filler, it’s the filler — the person who’s using the product. There’s an art form in understanding the muscles of the face, which is why you get the best results from a board-certified physician in one of the four core specialties [dermatology, ophthalmology, otolaryngology, and plastic surgery].” Her “mantra” as she instructs residents and practicing physicians, she said, is to “think lateral before medial, and think superior before inferior. There’s an over-fascination with the nasolabial folds, but that isn’t what ages the face; it’s the hollowing and downward shift. So when you inject laterally, it lifts more medially, and when you inject superiorly, you lift more inferriorly.” Dr. Weinkle, who said she has been injecting fillers since 1979, agreed that optimal results derive from “the art and skill of understanding the vessels and nerves, and how to maximize the injection. We can talk about which products till the cows come home, but it’s really about the person behind the syringe.”

Editor’s note: Dr. Butterwick serves on the advisory board for Allergan, Merz, and Valeant. She is a principal investigator for Voluma (Allergan) and PurTox (Mentor). Dr. Katz, Dr. Matarasso, and Dr. Sobanko reported no conflicts. Dr. Weinkle is a consultant for Merz, Allergan, Valeant, and Galderma. dw

ROLE OF FILLERS EVOLVES

In the May issue of the Journal of the American Academy of Dermatology, which is honoring the Academy’s 75th anniversary in 2013 by publishing an article each month acknowledging previously published articles that had significant impact on the practice of dermatology, C. William Hanke, MD, MPH, reflected on how much things have changed since he coauthored “Dermal implants: Safety of products injected for soft tissue augmentation” in 1989. The ensuing years have seen the introduction of hyaluronic acid, poly-l-lactic acid, and calcium hydroxylapatite, with nine different agents approved by the Food and Drug Administration between 2003 and 2011. As Dr. Hanke noted, “the clinical trials on the new filler materials and the development of safe and effective injection techniques have been led almost exclusively by dermatologists.”

To read the full article, “Evolution of filler materials in dermatology” (J Am Acad Dermatol 2013; 68:858-9), visit www.jaad.org/article/50190-962212/0934-6/fulltext. To learn more about the AAD’s 75th anniversary, visit www.aad.org/75th.
Options for advertising, marketing, and branding one’s practice are more diversified than ever — billboards, radio ads, websites, a Facebook presence, and more. But dermatologists and practice managers are increasingly finding the best boost to their reputation comes from the old ways — one-to-one patient outreach, community activities, and focusing on public health messages.

FINDING NEW OUTLETS
Marketing a medical practice is, at its heart, an attempt to raise the image or reputation of a practice and/or its physician or physicians in the eyes of the community it serves. While undertaking a campaign in the modern era presents near-unlimited possibilities for tone, content, and delivery, consumers faced with myriad advertisements in their daily lives are better than ever at tuning out advertising messages. Fairmont, W. Va., dermatologist Beth Rosenberger, MD, said that while she came to her practice with largely subsidized advertising from the local hospital that recruited her, she found that forming a steady relationship with a reliable patient base was better served by offering free public skin cancer screenings.>>
The number one way that patients hear about us is word of mouth. We get referrals from existing patients and their family members. Once you’ve established the messaging you can do, the best advertising you can do is to do your best every day. That’s where it really counts,” she said. “I did a lot of advertising in different media for the first few years I was in practice. But I also like to be efficient with the way I spend money. You pay for these tiny ads in a phone book or newspaper and you don’t know if people are going to look at them. If I do a screening, I know how many people I’ve contacted, and I’ve also given a skin cancer screening while I’m at it.”

Rennie Ackerman, marketing manager of New Jersey-based Dermatology Group, P.C., said that her 15-physician practice has also reduced its investment in traditional advertising in recent years, instead devoting more resources to education and community outreach events focused on public health issues such as skin cancer or sun protection.

“When we’re doing speaking events and skin cancer screenings locally, it still takes staff time and resources, but it’s not advertising the practice as much as it is the physicians. It helps them connect with patients and educate the public,” Ackerman said. “We like to think of ourselves as a big practice with a small-town feel, and part of that is getting the public to know our doctors personally. It creates a connection and rapport with the community — patients recognize our physicians in line at the movie theater or at the coffee shop. It’s not advertising, it’s health messaging that increases the visibility of our physicians and practice.”

To maximize both the effectiveness of community messaging and efficiency of staff time, Ackerman runs the community outreach activities through a centralized process that she oversees.

“Even if the doctors have an event they want to participate in, we make sure it travels through the department so we can schedule it accordingly. I may have

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**RECOGNIZING RESULTS**

While the immediate results of an investment in equipment or a building expansion are readily apparent, tracking the impact and effectiveness of marketing dollars can be more elusive. The issue is compounded when comparing traditional media spending (newspaper ads, billboards, radio spots) to spending on new media (banner ads, online videos or blogs, website enhancements).

To start, the total results of a given campaign are calculated by first determining new business that arrives on or after the date of a piece or campaign running.

For more specificity in static media such as the phone book, a billboard, or commercial, according to dermatologist Beth Rosenberger, MD, the advertising company can assign and forward a phone number specific to a given advertisement. The number of calls through that number are tracked by the advertising company and reported regularly, so that a physician can see exactly how many new patients or appointments come via the advertisement.

Online metrics, on the other hand, are built into the design of the Web advertising company’s infrastructure. The cost of advertising is typically presented in cost per thousand (CPM), offered by both views (how many Internet users will see it during their navigation) and clicks (how many actually click through the ad), with CPM click costs being significantly higher.

Matt Ragas, assistant professor of communication at DePaul University, advocates dovetailing social media activities with online campaigns to bolster the messaging with content that doesn’t sound like paid advertising.

“A lot of small businesses, including medical practices, generate engagement online by framing their marketing efforts so it doesn’t look as though they’re hitting the consumer over the head with one message,” Ragas said. “It can bolster the money you’re spending on advertising, both print and digital. If someone finds your content compelling, they can click through to your practice site, or they may make the connection if they see one of your ads somewhere.”

To calculate the results of a campaign, divide the total amount of new income by the total cost of the campaign. The number left is the return on investment (ROI), as indicated by the equation $TI/MC = ROI/$1, where total new income, divided by marketing costs, equals the return on investment per dollar. By replacing the total new income with the number of new patients, one can calculate the number of marketing dollars used to draw a new patient.
to block the doctor’s schedule, which could affect other staff. We have a lot of providers and staff, so I want to make sure they schedule it correctly.” Ackerman said. “Over 75 percent of our physicians and staff participate in these programs, and you could honestly spend an entire career just doing these.”

Ackerman’s process involves creating a master calendar that includes both events chosen by her or the practice owners as well as events brought to her attention by practice physicians interested in participating in a certain event. She will dispatch employees based on both stated interest and personal connection with the community. Many of the practice’s dermatologists, she said, want to participate in events in and around the towns they reside in.

**DELIVERING THE MESSAGE**

Espie Byrd, the marketing and revenue manager for multi-state practice West Dermatology, found that in order to better focus on delivering public health messaging to the underserved communities in several practice locations, it was necessary to create a department solely for that purpose. Most often, this was because a new practice location had opened in an area that was previously devoid of dermatologists who accepted Medicare and some lower-paying insurance plans.

“We found that the messaging we needed to push was substantially different in some communities with traditionally underserved patient populations. We established something we refer to as our community outreach program that allows us to advertise or message specially about how to detect, prevent, and be aware of skin cancer,” she said. “We’ll go to health fairs, senior centers — really, anywhere that will have us. We do 20-minute presentations where we hand out AAD pamphlets and make an RN or PA available for more education on skin cancer and skin protection. They often accompany one of our physicians in a support role. Sometimes people are more comfortable asking questions of an RN or PA.”

Ackerman also distributes practice-designed patient education materials, which she and the physicians at the group design with clear, concise messaging on the importance of skin cancer awareness and the need for testing.

“It’s practice-branded material, but the overriding message is that skin cancer awareness is necessary. We’ve put it in the air, so that even if you don’t go to our screening, the message sinks in,” Ackerman said. “It might trigger a patient to see a mole that has changed and get them to a dermatologist to see it checked out. You’re putting that out into the world, focusing the message, and I’m a big believer in that.”

Dr. Rosenberger said that she finds patients that approach her at talks or during health fairs with questions often find it far easier to approach her than patients who meet her in an exam room for the first time.

“It helps for people to meet you one-on-one in a non-threatening environment like a public event,” Dr. Rosenberger said. “A lot of times, people have anxiety about calling a new physician and coming to their first appointment. But if they see you at an event or even just in public, they’ll come and talk to you, and ask questions.”

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**GETTING THE MESSAGE OUT**

To reach out to patients in ways that reach beyond a static monthly ad buy, physicians and practice managers recommend the following methods.

1. **Health fairs**: Attending a health fair allows one to present a more approachable front to patients. Dermatologist Beth Rosenberger, MD, said that she finds that patients are far more likely to approach her with questions in a room full of health care professionals than when she is in the office.

2. **Skin cancer screenings**: Offering free screenings serves a twofold purpose. One can make connections with potential new patients while spreading a message about the importance of sun safe behaviors.

3. **Outreach events**: Senior centers, nursing homes, and private clubs often welcome medical professionals to speak on health matters. This is an effective way to reach some patients who might be underserved or hesitant to visit the doctor on their own.

4. **Printed material distribution**: Making either Academy or self-printed skin care material available to patients both in the waiting room and at all of one’s public events further important health messaging and creates a positive impression with potential patients. Some larger practices and groups print their own branded materials.

5. **Targeted advertising**: If there’s a perceived gap in the proportion of patients from a particular social group, targeted marketing can help reach that group and promote skin health awareness. Espie Byrd, director of marketing and revenue for West Dermatology, said that when her multi-state practice opens a new location in a traditionally underserved area, it will tailor its messaging specifically based on the demographics of the new location to enhance awareness of skin health issues.

6. **Radio/media appearances**: With an ever-growing roster of blogs and podcasts joining the traditional television, radio, and print media landscape, the number of chances to put oneself out as a skin health expert is higher than ever. Connecting with a local newspaper or radio show to offer advice on public health issues will enhance a practice and physician’s reputation in the community.
Outreach to underserved communities, Byrd said, required re-evaluating old ways of messaging. For patients with limited access to or interest in the Internet or television, alternative and free weekly newspapers proved an effective tool in drawing more patients for skin cancer screenings.

“We’ll look at the skin cancer screening numbers in a certain location and will take on monthly or biweekly ads to let the community know where we are if we see that there’s a need,” she said.

In addition, she said, the practice would purchase advertising in underserved communities that simplified the message in terms of descriptions of techniques or procedures. In many cases, the practice promoted services such as annual checkups and regular preventative care.

TRACKING RESULTS
In tracking the results of community-based messaging, gathering and maintaining metrics depends on having processes built into patient encounters that capture each patient’s cognizance and reception of the messaging, generating data that can be tracked. Byrd said that her practice’s electronic health record (EHR) software captures the answer to the question “Where did you hear about our practice?” as it is asked during appointment scheduling and is able to cross-reference it against the demographic and epidemiological data captured during the encounter. Analyzing this data, Byrd said, allows for a fairly sophisticated look at how and where specific outreach messages have been received.

“The way we look at our patients’ responses to ads or outreach events depends on the location and on our evaluation of the patient population,” she said. “The big picture is constantly changing around us. It’s important to be able to place yourself in an observer role and form an outline of a location or patient population.”

Another indication of increased physician or practice visibility is an increase in the number of speaking or educational invitations a dermatologist receives. Dr. Rosenberger, who said that she participated in every available type of advertising and community outreach event during her first handful of years in practice, was for a time a regular guest on a local radio show.

“I was starting a brand new practice in a community without a dermatologist. I took every opportunity that came my way at first,” Dr. Rosenberger said. “There’s a local talk radio show that I would go take calls from the public during skin cancer awareness week or rosacea month. That outlet was great for me, and I enjoyed it.”

Ackerman’s practice also saw increased efficiency in the messaging itself, in that local community health organizations began to pull together their own events. Her practice’s dermatologists can participate without the need for the practice to organize or advertise.

“I have been lucky enough to have been the recipient of the work done by the hosts of the screenings and events,” Ackerman said. “That leaves you free to try new events or a new messaging tactic on your own. During the month of May, we did community advertising for skin cancer screenings. We also did a press release, just to put the word out about melanoma awareness and sun safety. When you’re educating the public on their health, they’re typically very grateful.”

AAD RESOURCES TO GET THE WORD OUT
The American Academy of Dermatology offers a variety of resources that can help members to serve the public while positioning themselves in their communities.

Many of these resources are part of the Academy’s SPOT Skin Cancer™ program. Members can participate in a free skin cancer screening using Academy-provided materials; visit www.aad.org/scs to learn more or order materials. They can sponsor an applicant for a Shade Structure Program grant, a good way to build a strong relationship with a particular school; learn more at www.aad.org/ssp. And they can conduct skin cancer education using presentations developed by the Academy, available at www.aad.org/spot-skin-cancer/understanding-skin-cancer/educational-resources.

Members can also raise their profiles through media interviews about dermatology topics, which are often of broad interest to the public. The Academy’s Media Relations Toolkit, available at www.aad.org/members/media-relations-toolkit, can help members with key messages and talking points about frequently addressed topics as well as tips on how to navigate an interview and build a relationship with a reporter.
It’s Time to Upgrade Your Website

SWITCH TO A COMPLETE WEB PRESENCE PLATFORM

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In-office ancillary services exception and the GAO report

As members of Congress seek ways to reduce the federal deficit and pay for a fix to the Sustainable Growth Rate formula, whether temporary or permanent, one of the items frequently on the table as a proposed “pay-for” is the in-office ancillary services, or group practice, exception to the Stark law. The exception is what allows dermatology groups to provide dermatopathology in-house without facing penalties for violating regulations that forbid self-referral within practices. Unfortunately, abuse of this exception by some now threatens its existence for all.

Actuaries have long believed that closing the exception would save the Medicare program money, with varying estimates depending on how such a closure is implemented. The Congressional Budget Office says closing part of the exception would save $1.6 billion over 10 years, while the Office of Management and Budget flips the digits, estimating the closure in the president’s proposed budget for 2014 would save $6.1 billion. Recently, the Government Accountability Office (GAO) gave supporters of closing the exception a boost with a report that became public on July 15 and indicated that when dermatologists, urologists, and gastroenterologists start referring anatomic pathology in-house, they immediately begin referring significantly more pathology to their own practices than they had previously been sending out.

The Medicare Payment Advisory Committee, or MedPAC, which advises Congress regarding Medicare payment policy, has previously suggested that closing the exception is the wrong way to achieve cost savings. It says that such a move could have “unintended consequences, such as inhibiting the development of organizations that integrate and coordinate care within a physician practice.”

The AADA’s policy statement is similar, and notes that closing the in-office ancillary services exception would have a deleterious effect on the ability of dermatologists to provide integrated care to their patients. It would prevent dermatologists from practicing to the full extent of our training, which includes significant residency experience in pathology. And it could have, as MedPAC warns, other unintended consequences, like putting Mohs surgery, which combines surgery and pathology, in a regulatory grey area. It could also make it impossible for dermatologists to offer immediate diagnosis and treatment of some conditions, creating the need for return visits, missed days of work by the patient, and potentially patient discomfort.

However, if Congress closes the exception, the data suggest that dermatologists may, in part, be culpable. While the GAO report’s methodology was imperfect, its conclusions are all but irrefutable: on average, dermatologists, gastroenterologists, and urologists who brought their pathology in-house during the study period referred more pathology to themselves than they had previously referred out. In aggregate, 918,000 more specimens were read in-house in 2010 by self-referrers than would have been referred out. After searching for any other explanation for this change, the GAO concluded that the financial incentives for self-referring were to blame, and said this behavior cost Medicare an extra $69 million in 2010 alone, not to mention additional co-pays made by patients. What is at risk may be no less than our scope of practice and our right as dermatologists to read slides and run labs.

The AADA issued a strong response to the GAO report, noting that we are “committed to working to ensure that pathology services are utilized in the most appropriate and cost-effective manner.” We call upon all Academy members to evaluate their practices and help us fulfill this commitment. We can, and we must, guarantee that we use pathology services in only the most appropriate and cost-effective manner, which is that which best serves the needs of our patients.

Prior to the release of the GAO report, the push to eliminate the in-office ancillary services exception to Stark had not yet attracted a congressional sponsor. But in its wake, a bill that would close the exception for anatomic pathology, as well as advanced imaging, radiation therapy, and physical therapy, was introduced in the House. It would be a terrible irony for us to finally achieve long-sought Medicare payment stability, only to have it paid for in part by gutting our ability to use the full spectrum of our training to provide the best possible care for our patients.

Signed by the Officers, Board of Directors (current and incoming), and Board Observers

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Nominate or Apply Today!
The tradition continues.

Join us in celebrating and recognizing the accomplishments of distinguished members of the dermatologic community.

The Academy welcomes submissions for the following award categories:

- Named Lectureships
- Service to the Specialty
- Humanitarian

Submission deadline is October 15.

To learn more, visit www.aad.org/awards.
Dermatology moves forward with reform

EXECUTIVE DIRECTOR’S REPORT

YOUR MEMBER LEADERSHIP took very important steps this summer to ensure the future of the dermatology profession.

The AADA leadership convened a health policy retreat and brought together 100 dermatologists from across the country, representing a diversity of age, experience, geography, and practice settings. Your president, Dr. Elston, described the process of the retreat they held in his column last month. I want to review the priority issues that were identified, how we have already been actively engaged in many of them, and how we are planning to do more. But first, I want to reflect on the change we saw at this retreat.

This was not the first time Academy leaders gathered for a health policy retreat in the wake of the Affordable Care Act’s passage. In 2011, a similar group of members gathered to discuss how the organization should respond to health care reform. The battle over the law’s passage was then quite recent; the anger at some of its most troubling provisions was fresh and sharp. Resistance to making changes to adapt was high — surely, many thought, we and others could make this go away.

Fast-forward two years. The Supreme Court has weighed in on the issue. New rules based on the ACA are published in the Federal Register almost every week. At this year’s retreat, members were still frustrated by many provisions of reform — no one likes the IPAB, and many concerns about overall implementation remain. But that was not the focus of the conversation this time around. Members wanted to know what the Academy, and dermatology, needed to do to survive and thrive in a new health care environment.

How do we move forward? The retreat participants identified the following six priority issues:

- Guidelines, metrics, and outcomes: Defining and demonstrating value by creating a set of quality metrics that facilitate meaningful outcomes research.
- Team care business models: Developing best practices in dermatologic care coordination.
- Telemedicine: Advancing appropriate triage and teledermatology.
- Purchasers: Making the case for the value of dermatology.
- Primary care: Collaborating to develop mutually beneficial relationships.
- Patients: Understanding their experience, increasing satisfaction, and improving adherence to treatment.

You can read more about the retreat process and outcomes at www.aad.org/retreatreport.

Identifying priorities is a starting point, not the end of the process. As the dermatologists at the retreat returned to their practices, Academy staff went to work looking at how the organization is already addressing each of the priority issues, what plans to address them are already in motion, and where new programs may be needed.

Fortunately, we found that in many cases we are already moving in the right direction. Members and staff have already been hard at work identifying the most important data needs of the specialty, which will facilitate our need for guidelines, metrics, and outcomes. Special task forces had already been convened to formulate plans for team care and telemedicine. A summit with medical directors was already scheduled for the weekend after the retreat. The fact that so much was already in the works shows me that when it comes to reform, dermatology has turned the corner.

Better than the news about how prepared we are as an Academy is how well-prepared the specialty is to thrive. Dermatologists offer cost-effective care, from all-at-once Mohs surgery to early detection of skin cancer, and receive high marks from patients in an era where both are set to be measured and rewarded. As we move ahead to act on the priorities identified at the retreat, I am confident that we can ensure that dermatology’s future is commensurate with the level of talent and dedication in the field.
Nominees sought for humanism award

THE ACADEMY’S VOLUNTEERISM COMMITTEE seeks nominations for the Arnold P. Gold Foundation Humanism in Medicine Award. The award recognizes physicians who are mindful of the life context of health and illness, and have become skillful in the habit of humanism, or how to communicate effectively and empathically to help patients heal.

To be eligible for the Humanism in Medicine Award, nominees must meet at least five of the following criteria:

- Demonstrate compassion and empathy in the delivery of patient care
- Show respect for patients, families, and coworkers.
- Demonstrate cultural sensitivity when working with patients and family members of diverse backgrounds.
- Display effective, empathetic communication and listening skills.
- Understand a patient’s need for interpretation of complex medical diagnoses and treatments and make an effort to ensure patient comprehension.
- Comprehend and show respect for the patient’s viewpoint.
- Is sensitive to the patient’s psychological wellbeing and identifies the emotional concerns of patients and family members.
- Engender trust and confidence.
- Display competence in scientific endeavors.

The recipient will receive a monetary award of $1,000 and will be honored at the Academy’s recognition luncheon during the 72nd Annual Meeting in Denver, March 21 – 25, 2014. In addition, expenses for the winner to attend the Annual Meeting, including airfare and accommodations, will be reimbursed up to $2,000. The winner will also be recognized in Dermatology World, on the Academy’s website, and in other media where award-winners are covered.

Requests for nominations must be submitted online at www.aad.org/HumanismInMedicine by Oct. 15, 2013. For more information, contact Nikki Haton at nhaton@aad.org or (847) 240-1350.

– NIKKI HATON

American Board of Dermatology announces 2014 exam dates

THE AMERICAN BOARD OF DERMATOLOGY has announced dates and locations for the 2014 in-training, certification, and recertification exams. For more information visit the ABD website at www.abderm.org.

- RICHARD NELSON

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Nominations sought for 2014 AAD election

THE AMERICAN ACADEMY OF DERMATOLOGY

Nominating Committee seeks nominees for the offices of president-elect, vice president-elect, Board of Directors and Nominating Committee member representatives (NCMR) in the Western Region. The current Administrative Regulation on Nomination and Election Procedure requires that nominees submit all the required materials to the Nominating Committee no later than Nov. 1, for the election that will take place in spring 2014.

Successful officer and director candidates will take office in March, 2015, at the close of the 73rd Annual Meeting in San Francisco and the successful NCMR will take office immediately. Nominees for the offices of president-elect and vice president-elect must have served on the Academy Board of Directors for at least one year prior to assuming office. President-elect nominees incur a four-year commitment — a one-year commitment prior to president-elect, one as president-elect, one as president, and one as immediate past president. Vice president-elect nominees assume a three-year commitment — a one-year commitment prior to vice president-elect, one as vice president-elect, and one as vice president.

The Nominating Committee screens and evaluates all nominees and selects a definitive slate of candidates based on professional, scholarly and administrative skills, and geographic representation. Remember, make your nomination(s) early to ensure that nominees have the necessary time to complete and submit all the required materials no later than Nov. 1.

The 2014 Nominating Committee Fellows of the American Academy of Dermatology are John C. Maize, MD, chair, Raymond L. Cornelison Jr., MD, Lawrence F. Eichenfield, MD, C. William Hanke, MD, MPH, Amy J. McMichael, MD, Stephen M. Purcell, DO, and Darrell S. Rigel, MD.

Submit nominations to www.aad.org/nominate or by mail at:
American Academy of Dermatology
Attn: Call for Nominations
930 E. Woodfield Road
Schaumburg, IL 60173-4729

For more information, contact the AAD Executive Office at callfor nominations@aad.org or (847) 240-1046. - JOAN TENUT

UNAUTHORIZED MEMBER ACTIVITIES

No member of the American Academy of Dermatology shall directly contact any member of the Nominating Committee regarding nominees under consideration. All letters of support and/or nominations should be addressed to the Nominating Committee chair at the Academy’s Schaumburg headquarters. Any lobbying of committee members may eliminate the nominee from consideration by the Nominating Committee.

FINANCIAL RELATIONSHIPS

President-elect candidates must agree to abide by the following excerpt from the administrative regulation on code for interactions with companies:

1.4. No Key Society Leader, defined for purposes of this Code as the Presidential-level of a Society’s membership organization [e.g., the President, President-Elect, and Immediate Past President as applicable],... may have Direct Financial Relationships with Companies during his or her term of service.

Direct Financial Relationship*: A Direct Financial Relationship is a relationship held by an individual that results in wages, consulting fees, honoraria, or other compensation (in cash, in stock options, or in kind), whether paid to the individual or to another entity at the direction of the individual, for the individual’s services or expertise. As used in this Code, the term Direct Financial Relationship does not mean stock ownership or intellectual property licensing arrangements. See Principle 1.4 for additional clarification of the meaning of Direct Financial Relationship.

*Definition: A Direct Financial Relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099 or equivalent income report. Key Society Leaders (including the President, President-Elect, Immediate Past President, the Secretary-Treasurer, Assistant Secretary-Treasurer, the chief executive officer of a Society’s membership organization, and the Editor-in-Chief of Society Journal[s]) may provide uncompensated service to for-profit health care products companies (“Companies”) and accept reasonable travel reimbursement in connection with those services. Key Society Leaders may accept research support as long as grant money is paid to the institution (e.g., academic medical center) or practice where the research is conducted, not to the individual. Exception may be made in certain circumstances for provision of consultant or investigator expertise related to protocol development and/or safety monitoring as long as the activities are not related to marketing or promotional efforts. In this event, the Secretary-Treasurer must be provided with background information and approval must be provided in advance for an exception to the policy. In these circumstances, compensation to the individual may not exceed $10,000/company/year. Verifying 1099 forms must be submitted to the Secretary-Treasurer when received. This exception may not be applied to the President, who shall remain free from any and all direct financial relationships during his/her term of office.
SIGNATURE SERUMS FOR ANY SKIN TYPE

After exfoliation using the DiamondTome™, Newapeel® or Newapeel® Petite System, infuse the skin with one of our four signature serums using the Hydrowand®.

Perfectly formulated and designed for optimum skin penetration, the HydroSerums™ can be an effective way to improve skin imperfections. Choose from Acne, Deep Hydration, Even Tone and Vitamin C. See for yourself the difference in your skin when combining an Altair Microdermabrasion, Hydrowand® Infusion and the New HydroSerums™, a perfect way to end your signature treatment.

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Visit us at www.altairinstruments.com and find out how to get The HydroPlus® Treatment in your salon.
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

Thanks for your thoughts!

EARLIER THIS YEAR, DERMATOLOGY WORLD mailed a survey about the magazine to 1,500 Academy members and offered those who completed it the chance to win one of five $50 AAD gift certificates. Congratulations to Elise Brantley, MD, Kim Dermovsek, MD, Dawn Kleinman, MD, Jamison Strahan, MD, and Hobart Walling, MD, who were randomly selected as the winners. More information about the survey’s results will appear in a future Facts at Your Fingertips column.

Want to offer your own feedback about Dermatology World? Email dweditor@aad.org. – RICHARD NELSON

Obituaries

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


Ernst H. Beutner, PhD, Buffalo, N.Y. Died June 10.

Arthur R. Birt, MD, Winnipeg, Manitoba.


Leroy George Ferber, MD. Completed dermatology residency training at New York University Medical Center. Died Nov. 17, 2012.


Gerald G. Overly, MD, Boise, Idaho. Completed dermatology residency training at University of Missouri Medical Center. Died April 2.


Obituaries are published in Dermatology World after information is submitted to the AAD. Information on member obituaries should be submitted in writing to Member Resource Center, AAD Member Services Dept., P.O. Box 4014, Schaumburg, IL, 60168-4014, via fax at (847) 330-1090, or via email at mrc@aad.org. dw
HIPAA and Omnibus Final Rule On-Demand Webinar Series

This new three part on-demand webinar series explains the history of HIPAA and identifies steps dermatology practices should take to prepare for the new rules by the compliance deadline of September 23, 2013.

- HIPAA and Omnibus Final Rule: Overview
- HIPAA and Omnibus Final Rule: Privacy
- HIPAA and Omnibus Final Rule: Security

AAD Member Price: $149 each
Purchase all three for $297 - BEST VALUE!

And don’t forget to order the newest practice management manual, *A Guide to HIPAA and HITECH for Dermatology*!

To purchase, visit www.aad.org/store
AADA names Advocate of the Year

In recognition of his constant efforts to advocate on behalf of dermatology, the American Academy of Dermatology Association (AADA) named State University of New York at Stony Brook dermatologist and Mohs surgeon Jordan Slutsky, MD, its Advocate of the Year at the SKinPAC/DAN reception at its 71st Annual Meeting in Miami Beach, Fla.

Dr. Slutsky was chosen for the award after a year spent advocating for the specialty through the AADA’s Dermatology Advocacy Network (DAN). He answered every 2012 call to action, contacted his representatives in the state and federal legislatures, and helped inform members of Congress on issues such as skin cancer prevention and Medicare reform.

“I was honored to receive the award, and even a bit surprised. I did not realize I was involved in every call to action, nor did I think it was as above and beyond what others in the field were doing. Email blasts make contacting politicians as easy as a few clicks of the mouse,” Dr. Slutsky said. “With the changes happening to our health system and the uncertainty about the future, it has never been more important for dermatologists of all ages to take time out of our busy schedules to advocate for our specialty.” - John Carruthers

Members Making A Difference:
Maryam Asgari, MD, MPH
Dermatologist Brings Specialty Care to Ghana

IN AN EFFORT TO BRING world-class medical care to the remote village of Yamoransa, Ghana, located two hours from any formal medical care, Kaiser Permanente dermatologist Maryam Asgari, MD, MPH, joined up with a host of medical colleagues for a two-week trip through a program set up by the Yale Alumni Service Corps.

In doing so, Dr. Asgari was also able to bring along her then 10-year-old son, who helped teach village children and experience an entirely new culture.

“Even temporarily being able to alleviate human suffering is a gift.”

- Dr. Asgari traveled to Ghana as the only dermatologist in a team of 30 medical professionals. Other specialists present for the trip included pediatricians, cardiologists, and ophthalmologists. Upon arrival, the entire team talked through how to provide triage, discussed specialties, and set up a clinic at the local school.

- The clinic site required the physicians to work with extremely limited resources, such as unreliable electricity and no running water in the village. Treatment required the judicious use of donated medicines and supplies, as well as a range of dermatologic treatments that Dr. Asgari secured from dermatologist colleagues.

- “I come in to a very structured environment most days. I can open up a schedule book and see my day from 9 to 5. Here there was a tremendous line of patients in various levels of acuity,” Dr. Asgari said. “There was actually no end to the number of patients that needed to be seen. It’s both humbling and disheartening. Every time you’d look out, there would be more people in line.”

- “On our fourth day there, it was very hot and very tight quarters. At the end of our afternoon shift, we were somewhat disheartened. Up comes this lady that had been carried to our clinic with terrible crippling arthritis by her family three days before. The rheumatologist and I saw her together and gave her treatment with prednisone,” Dr. Asgari said. “Three days later she was able to walk to the clinic with a stick and tell us that it was the first time she had been able to walk in years. She brought us a basket full of bread to show us how grateful she was.”

- John Carruthers DOM

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

Media Highlight
Skin cancer and the new sunscreen labels were hot topics in the media all summer long and Academy members were at the forefront of media coverage. The Academy’s Melanoma/Skin Cancer Detection and Prevention Month media activities generated more than 122 million media impressions. Thank you to all the members who continue to share important skin cancer prevention messages with the media and their audiences.

In the July/August issue of Ladies’ Home Journal (circulation 3,230,450), “The Easier Way to Erase Wrinkles,” David Bank, MD, Jeannette Graf, MD, and Ranella Hirsch, MD, provide skin care tips from the countries in which they were born.

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
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PROFESSIONAL OPPORTUNITIES

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Solo dermatology practice for sale. Retiring. Interested parties contact cnordby@shorepointederm.com.

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ANN ARBOR, MICHIGAN
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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* 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 FT or PT. FT. Ideal candidates will be BC, possess two years of post residency experience and substantial interest in building a Dermatology Division, developing quality improvement projects, Tele-dermatology services, as well as curriculum development for both medical student and resident education. Candidates must possess excellent clinical/communications skills, commitment towards our multicultural, underserved patient population and a strong interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

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

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

**Southern New Jersey**

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

**NORTHERN VIRGINIA**

Unique opportunity for a business oriented, motivated BC/BE dermatologist to take over or being partner of a well-established, highly respected integrated dermatology practice. Located in Tyson Corner of Northern VA, suburb of Washington DC. Practice offers entire spectrum of general/pediatric/esthetic dermatology, with Palomar IPL/Fractional. Please send CV and a short bio to thdf402@gmail.com.

**Washington DC**

NW seeking a full/part time dermatologist to provide medical dermatological care. Please call office manager for more information (202) 965-7546 or info@cosmeticskininstitute.com.

**Pennsylvania**

Busy group of seven derms and one PA in a highly-regarded, well-established practice seeking a FT/PT BC/BE dermatologist. Our new state-of-the-art 12,000 sq. ft. facility includes general dermatology, Mohs with office-based surgical rooms, dermatopathology, lasers, phototherapy and an aesthetic center suite. Our continually growing population base offers a new dermatologist an established, large patient base with excellent managed care contracting and a very good insurance mix. We’re located within 1 hour of Philadelphia and Baltimore and 2 hours from NYC and enjoy a strong and diverse community. Call Bonnie Oberholtzer, Practice Administrator at (717) 509.5698 or email: bio@dermlanc.com. Website: www.dermlanc.com.

**Portland, Oregon**

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

**SALES INFORMATION**

**UPCOMING DEADLINES FOR FUTURE ISSUES:**

- November.................September 27
- December.................October 25
- January.....................November 25
- February...................January 3
- March*.....................January 24

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

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THE AD INDEX IS PROVIDED AS A COURTESY TO OUR ADVERTISERS. THE PUBLISHER IS NOT LIABLE FOR OMISSIONS OR SPELLING ERRORS.
Dermatologists may face a variety of reimbursement challenges in the future (see article, p. 20) — but the sustainable growth rate, or SGR, may not be one of them. After years of rising, the price tag the Congressional Budget Office assigns to a 10-year fix to the SGR — the figure by which budget proposals are judged in Washington, D.C. — has plunged in each of the last two years. As a result, congressional hearings this summer showed promise, and observers are optimistic that physicians may see something other than a months-long patch to address the problem. Despite calls from most major medical associations to find a permanent solution to the ongoing Medicare payment problem caused by the SGR, Congress has consistently passed temporary fixes, sometimes lasting only a few months, for most of the last decade.

The SGR formula, established by the Balanced Budget Act of 1997, sets a target for cumulative Medicare spending and requires spending in subsequent years to drop to make up for spending above the target in prior years. Until recently, that meant that the price tag for eliminating the SGR grew each year, making it harder and harder for Congress to find offsets to pay for fixing the problem. The chart below illustrates how the cost of a 10-year fix — defined simply as freezing payments at current levels — ballooned until the last two years of slower-than-expected medical spending growth. — Richard Nelson

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**SGR FIX SUDDENLY LOOKS AFFORDABLE**

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<th>Year</th>
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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.

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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:**

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