GETTING YOUR DUCKS IN A ROW FOR THE RAC

Preparation, balanced approach key for passing unscathed through process

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CLOBEX® (clobetasol propionate) Spray, 0.05%, is a super-high potent topical corticosteroid formulation indicated for the treatment of moderate to severe plaque psoriasis affecting up to 20% body surface area (BSA) in patients 18 years of age or older.

Important Safety Information
Clobetasol propionate has been shown to suppress the hypothalamic-pituitary-adrenal (HPA) axis at the lowest doses tested. Clobetasol propionate spray should not be used in the treatment of rosacea or perioral dermatitis and should not be used on the face, groin or axillae.

In controlled clinical trials, the following adverse reactions have been reported: burning, pruritus, hyperpigmentation, infections and infestations, nasopharyngitis, upper respiratory tract infection, and skin and subcutaneous tissue disorders.

Treatment should be limited to 4 weeks. Treatment beyond 2 weeks should be limited to localized lesions of moderate to severe plaque psoriasis that have not sufficiently improved after the initial 2 weeks of treatment with CLOBEX® Spray, 0.05%. CLOBEX® Spray, 0.05%, should not exceed 50 g (59 mL or 2 fl oz) per week. CLOBEX® Spray, 0.05%, is not recommended for use on anyone younger than 18 years of age. Pregnancy Category C.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088 (1-800-332-1088).

Please see adjacent page for brief summary of Prescribing Information.

*Eligibility Requirements: Offer not valid for prescriptions reimbursed or paid in part or full by any state or federally funded programs, including but not limited to Medicare or Medicaid, Medigap, VA, DOD, or TriCare. MSAZ is not responsible for any transactions processed under this program where Medicare, Medicaid, or Medigap ("Government Program") payment, in part or full, has been applied. Only patients who reside in the 50 states can participate in the CLOBEX® Spray PMVT $10 NELS Program, except patients in the state of Massachusetts. Cash-paying customers are not eligible for this program. There are age restrictions to this program—patients must be 18 years or older. There are no gender restrictions to this program. Each patient is eligible for 12 benefits, each consisting of a $10 copay for the patient with a maximum cap of $350 for CLOBEX® Spray 4.25 fl oz and $200 for CLOBEX® Spray 2.0 fl oz. Maximum reimbursement limits apply; patient out-of-pocket expense may vary.
CLOBEX® (clobetasol propionate) Spray, 0.05%

PROD BRIEF SUMMARY

INDICATIONS AND USAGE: CLOBEX® (clobetasol propionate) Spray, 0.05% is a super-high potent topical corticosteroid that has been shown to be efficacious in the treatment of moderate to severe plaque psoriasis in patients who are unresponsive to other, or intolerant of, corticosteroids or, or in any ingredient in this preparation.

PRECAUTIONS:

General: Clobetasol propionate is a highly potent topical corticosteroid that has been shown to suppress many of the signs and symptoms of glucocorticosteroid insufficiency when used for the treatment of psoriasis. Clobetasol propionate has greater affinity to the human recepfunction of the target tissue and may act at lower doses than other corticosteroids. Clobetasol propionate is contraindicated in patients who are known to be hypersensitive to any component of this medication.

A clobetasol propionate is not a systemic steroid and therefore treatment should be limited to 4 weeks. Treatment beyond 2 weeks should be limited to the area treated unless there is evidence of increased severity of the condition.

ADVERSE REACTIONS:

CLOBEX® (clobetasol propionate) Spray, 0.05% is a super-high potent topical corticosteroid. Clobetasol propionate has greater affinity to the human receptor and may act at lower doses than other corticosteroids. Clobetasol propionate is contraindicated in patients who are known to be hypersensitive to any component of this medication.

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Demonstrate compassion. Foster goodwill. Volunteer your time.

Be part of the inspiring effort growing among dermatologists dedicated to helping patients, communities and the profession.

Opportunities include patient/public outreach in the United States and abroad, mentoring young physicians, political advocacy, and Academy committees.

Be sure to submit your volunteer hours through the Volunteer Recognition program. It’s quick and easy!

For more information about AAD volunteer and mentor opportunities, and the Volunteer Recognition program, visit www.aad.org/volunteerandmentor.
DEAR READERS,

Memorabilia of the founding fathers of this country is omnipresent in Philadelphia.

Signs abound attesting to where George Washington slept and ate. Somehow they are most apparent in February as we head into Presidents’ weekend and George Washington’s birthday. Since George (as we in Philly say) and my mother shared a birthday I have always been most intrigued by him. I often find myself wondering about the founding fathers — what made them so visionary? They were able to think beyond the accepted norms of their day and create a new type of government. We in the U.S. were lucky to have had leaders who could think outside of the box and challenge the status quo back then. Not sure which side of the political aisle you sit on, but I wish there was more of this kind of thinking on both sides today.

We have a few articles this month which are also challenging the medical assumptions of our day. Our Acta column highlights concerns that dermatologists have with the CDC guidelines on botulinum toxin. These rules were created by the CDC based on poor practice standards where multiple patients were injected with the same needle, so-called “double dipping.” Hard to imagine that 30 years after the arrival of the HIV/AIDS epidemic that would even be part of any discussion. However, in talking with David Ozog, MD, it is clear that we are left with rules that enforce unnecessary waste for practitioners and patients alike. His paper on the reconstituted and storage of botulinum toxin type A in the JAAD directly challenges the CDC view. He highlights the lack of infections noted in the dermatologic community when vials are used for multiple patients rather than single use, the durability of the toxin once mixed over weeks rather than days, and the advantages of reconstituting botulinum toxin with saline rather than the recommended diluent. Hopefully this will get the CDC thinking a little differently given the uniform success of these approaches by dermatologists across the nation.

Another assumption that dermatologists are questioning concerns the implementation of cosmetic taxes by some of our individual state houses. The assumption in many cash-strapped states has been that this would create a financial windfall. Connecticut has just recently implemented this type of tax, while other states tried to do the same but were not successful. One of this month’s features reviews the outcomes of New Jersey’s cosmetic tax — and this couldn’t be more timely, as a bill repealing the law was signed into law just as we went to press. We discuss many of the assumptions about this tax — ranging from the amount of monies that could be generated to the characterization of this tax as a rich person’s tax. Read it for yourself...maybe forward it to your local governor’s office.

I truly hope that you like our debuting column called “Technically Speaking.” For most of us in 2012 not much could be worse than our computer systems crashing. But we all need to accept this reality and in fact be willing to plan for this crash. We have fire drills where our patients question whether they are truly supposed to go outside without their clothes on — guess the next step will be computer crash drills where we will return to the days of handwritten scripts that patients take to the pharmacies themselves...how 1790s.

Enjoy your reading.

ABBY S. VAN VOORHEES, MD, PHYSICIAN EDITOR
“If you don’t respond to a RAC audit properly and in a timely fashion, you’ve lost.”

FEATURES

COVER STORY
GETTING YOUR DUCKS IN A ROW FOR THE RAC
Preparation, balanced approach key for passing unscathed through process
BY JOHN CARRUTHERS

EMPTY PROMISES
Cosmetic tax fails to raise expected revenue in New Jersey, Connecticut starts down similar path
BY RUTH CAROL

ATTACKING ACTINIC KERATOSES
Multiple modalities let dermatologists tailor treatment to the patient
BY JAN BOWERS

DEPTS

FROM THE EDITOR

CRACKING THE CODE
Avoid downcoding by documenting a review of systems.

ROUNDS
Meaningful use criteria update delayed, more.

ACTA ERUDITORUM
Is use of a single vial of botulinum toxin for multiple patients safe?

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Crisis management: Planning for a systems crash.

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Complying with the law while treating patients with special needs.

FROM THE PRESIDENT

ACADEMY UPDATE
Election info, Advisory Board resolutions sought.

ACCOLADES

FACTS AT YOUR FINGERTIPS
EHR satisfaction in dermatology.
Available in

45-9 tubes

(NDC 0145-2371-05)
Avoid downcoding by documenting a review of systems

DIRK M. ELSTON, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Elston, who serves as director of the Ackerman Academy of Dermatopathology in New York, has represented the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

The review of systems (ROS) is the most common portion of the history that clinicians forget to document. This can result in downcoding of an evaluation and management (E/M) visit. All E/M levels above a new patient level one (N1, 99201) require a ROS, as well as the levels above an established patient level two visit (E2, 99212) if history is being used as one of the two required components to satisfy the documentation of an established visit.

The Centers for Medicare and Medicaid Services (CMS) defines the ROS as “an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.” Organ systems, rather than bullets, are counted, so if the patient is asked about other rashes or skin lesions, this counts as a single organ system. Likewise, “fevers, chills, and weight loss” count as a single system (constitutional symptoms). As with other elements of the history, it is only appropriate to document questions that are relevant to the visit.

At least one question should relate to the same organ system as the presenting complaint. For dermatologists, this would, of course, be the skin. There are very few visits where it would not be appropriate to ask about a history of new or changing moles.

For purposes of ROS, CMS recognizes the following systems:

- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

A problem-pertinent ROS inquires about the system directly related to the problem(s) identified in the history of present illness (HPI). Both positive and negative responses should be documented. An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems (two – nine additional systems). A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems. While at least 10 organ systems must be reviewed, only positive and pertinent negative responses need to be documented. For the remaining systems, a notation indicating “all other systems are negative” may be permissible. Check with your local carrier.

A quick translation of the above is that for an N2 (99202) or E3 (99213) E/M visit, at least one question related to the skin should be documented. For an N3 (99203) or E4 (99214) E/M visit, at least two organ systems (including one question related to the skin) should be documented. For an N4 (99204) or E5 (99215) E/M visit, at least one question related to the skin should be documented specifically along with a statement that “all other systems were negative,” assuming that the questions were appropriate to the visit, in fact, asked, and allowed by the carrier.

A brief review of the required history elements for each level of service is noted on p. 7.
### Visit level | Required elements | Examples
---|---|---
**Problem focused** | Chief complaint (CC), Brief HPI (1-3) N1 [99201], E2 [99212] | Example of an N1 history: A 59-year-old female presents with a new papule on the right arm.

**Expanded Problem focused** | CC, Brief HPI (1-3), 1 ROS N2 [99202], E3 [99213] | Example of an N2 history: A 59-year-old female presents with an itchy rash on the left leg. 
**ROS:** She has no other rash or skin lesions, and no new or changing moles.

**Detailed** | CC, Expanded HPI (4+), 2 ROS, 1 past medical, family and social history [PFSH] N3 [99203], E4 [99214] | Example of an N3 history: A 59-year-old female presents with a three-week history of an intensely itchy rash on the left leg. It occurred after gardening and has not responded to 1 percent hydrocortisone. Erythema has been spreading over the past three days, but there is little tenderness. 
**ROS:** Skin: She has no other rash or skin lesions, and no new or changing moles. 
Constitutional: Despite the spreading erythema, she has no fever or chills. 
Social History (SH): She works as a florist.

**Comprehensive** | CC, Expanded HPI (4+), 10+ ROS, 1 each past medical, family, and social history N4 [99204], E5 [99215] | Example of a comprehensive [N4] history (note that for each example, the other elements of the visit – physical exam and medical decision making — would also have to match the reported level of service): 
A 59-year-old female new patient, with a history of malignant melanoma excised in 2007 by a general surgeon. It was located on the right thigh and was 0.9 mm in depth with no ulceration or regression, and a mitotic index < 1 mm squared. Her complaint today is a three-week history of an intensely itchy rash on the left leg. It occurred after gardening and has not responded to 1 percent hydrocortisone. Erythema has been spreading over the past three days with a little tenderness. 
She is being followed for systemic lupus erythematosus by a rheumatologist, but she has also seen a dermatologist for cutaneous lesions. None are active currently because she has been on systemic treatment recently for her renal disease. 
**ROS:** Skin: She has no other rash or skin lesions, and no new or changing moles. 
Hematopoietic: She has experienced no lymphadenopathy. 
Constitutional: Despite the spreading erythema, she has no fever or chills. 
Pulmonary: She reports a new cough two months ago related to other cold symptoms. It resolved and she now has no ongoing pulmonary symptoms. 
She has had generalized arthralgia and photosensitivity in the past, but none recently. 
All other systems were reviewed and are negative. (Some carriers allow this statement. Many others require every system to be bulleted.) 
Past Medical History: A congenital nevus was excised from her right arm as a child. She has mild asthma and is prone to wheezing after mild viral infections. 
Her lupus flared recently and she was started on prednisone and cytotoxic therapy. 
Family History: Her uncle died of melanoma and many family members have atypical moles. She has a cousin with lupus. 
SH: She works as a florist. **dw**
Medicare payments remain level to start 2012
CUT AVERTED BY LAST-MINUTE TWO-MONTH FIX

A cut in Medicare payments of 27 percent that would have taken effect Jan. 1 was averted by a law signed Dec. 23 that extended 2011’s payment rates, along with a payroll tax cut of 2 percentage points and benefits for the unemployed, for the first two months of 2012. A conference committee between the House and Senate was appointed to work out details of a full-year extension that would keep Medicare payments level until the beginning of 2013. The AADA urged Congress to use this short reprieve to address the unsustainable physician payment structure and create permanent stability within the Medicare program. Dermatologists may notice slight changes in their payments for services provided after Jan. 1 due to the implementation of changes included in the 2012 fee schedule, including a budget neutrality adjustment that slightly increases the 2011 conversion factor from $33.9764 to $34.0376.

The last-minute deal had already led the Centers for Medicare and Medicaid Services to announce that it would hold claims for the first few weeks of 2012 if Congress had not yet acted in order to pay them once at the proper rate rather than retroactively updating them. Given the new deadline looming at the end of this month, CMS may make a similar announcement soon; the Academy will keep members informed through Dermatology Advocate, aad.org, and member alerts. – RICHARD NELSON

Supreme Court schedules health reform case for March
THE SUPREME COURT ANNOUNCED IN DECEMBER that it would hear a nearly unprecedented five-and-a-half hours of oral arguments regarding the Patient Protection and Affordable Care Act, 2010’s health system reform law. At issue:
- The constitutionality of the law’s individual mandate, which requires all Americans to have health insurance or pay a penalty.
- Whether the court can rule on that mandate’s constitutionality before it takes effect in 2014 or must wait to hear cases regarding it due to the Anti-Injunction Act, which does not allow litigants to challenge a tax (which suits against the law argue the individual mandate imposes through the penalty for not purchasing insurance) until they have to pay it.
- Whether, if it strikes down the individual mandate, the court can let the rest of the law stand or must strike it down in its entirety.
- Whether the law’s expansion of Medicaid unlawfully forces states to expand their own programs or drop out of Medicaid funding altogether.

After hearing the case on March 26, 27, and 28, the court is likely to deliver its decision in June. In the meantime, implementation of provisions of the law continues. – RICHARD NELSON

Stage 2 of meaningful use delayed to 2014
DERMATOLOGISTS WHO HAVE ALREADY ADOPTED AN ELECTRONIC HEALTH RECORD (EHR) SYSTEM and attested to being meaningful users of that system in 2011 made themselves eligible for an $18,000 incentive payment, part of up to $44,000 in incentives available from Medicare over the course of five years. A recent announcement will make it easier for those dermatologists to continue receiving incentive payments.

In a rule scheduled to be published this month, the Centers for Medicare and Medicaid Services will delay by a year the requirement for EHR adopters to attest using stage 2 meaningful use criteria, which are currently in development but are expected to have more extensive and rigorous requirements regarding data exchange between providers. Such requirements were scheduled to take effect in 2013 for providers who started the meaningful use process in 2011 but will now be delayed until 2014 for all providers. The extra time, CMS indicated, should allow vendors to create functionality to meet stage 2 criteria and give providers more time to implement that functionality before attesting to its use.

Dermatology World will cover the development of stage 2 meaningful use criteria and where things stand for dermatologists considering adoption in a feature on the topic later this spring. Dermatologists at any stage of the EHR adoption process, from considering whether an EHR system is right for them to tweaking their system to make it work better for them, will find resources to help them in the Academy’s HIT-Kit, available at www.aad.org/hitkit. – RICHARD NELSON
Power with ease!

Now in a ready-to-use 50g pump

- Neat and simple: No jar, no mess
- Measured dose: Consistent delivery
- Longer shelf life: 10 weeks’ stability at room temperature
- Convenience: Easily portable and meets TSA liquid carry-on limits

Indication and Important Safety Information
Acanya Gel is indicated for the topical treatment of acne vulgaris in patients 12 years of age or older. Acanya Gel is contraindicated in patients with a history of regional enteritis, ulcerative colitis, or antibiotic-associated colitis. Discontinuation is recommended if significant diarrhea, bloody diarrhea, severe abdominal cramping, or colitis (including pseudomembranous colitis) develops. Clindamycin taken orally or through IV may result in severe colitis, which may result in death. Anaphylaxis, as well as other allergic reactions leading to hospitalizations, has been reported in postmarketing use of products containing clindamycin/benzoyl peroxide. If a patient develops symptoms of an allergic reaction such as swelling or shortness of breath, they should be instructed to discontinue use and contact a physician immediately. Patients should be advised to avoid contact with the eyes or mucous membranes and to minimize sun exposure following the application of Acanya Gel.

To learn more, please visit www.AcanyaGel.com

Please see brief summary of prescribing information on adjacent page.

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

*Individual results may vary.

**ACANYA®**

*(clindamycin phosphate and benzoyl peroxide) Gel, 1.2%/2.5%*

**Ready-To-Use 50g Pump**

**ACANYA Gel** is indicated for the topical treatment of acne vulgaris in patients 12 years and older.

**INDICATIONS AND USAGE**

ACANYA Gel is indicated for the topical treatment of acne vulgaris in patients 12 years and older.

**DOSES AND ADMINISTRATION**

Apply a pea-sized amount of ACANYA Gel to the face once daily. Use of ACANYA Gel beyond 12 weeks has not been evaluated.

ACANYA Gel is not for oral, ophthalmic, or intravaginal use.

**CONTRAINDICATIONS**

ACANYA Gel is contraindicated in patients with a history of regionalenteritis, ulcerative colitis, or antibiotic-associated colitis.

**WARNINGS AND PRECAUTIONS**

Colitis

Systemic absorption of clindamycin has been demonstrated following topical use of clindamycin. Diarrhea, bloody diarrhea, and colitis (including pseudomembranous colitis) have been reported with the topical use of clindamycin and systemic clindamycin. When significant diarrhea occurs, ACANYA Gel should be discontinued.

Severe colitis has occurred following oral and parenteral administration of clindamycin with an onset of up to several weeks following cessation of therapy. Antiperistaltic agents such as opiates and diphenoxylate with atropine may prolong and/or worsen severe colitis. Severe colitis may result in death.

Studies indicate toxin(s) produced by Clostridium is one primary cause of antibiotic-associated colitis. The colitis is usually characterized by severe persistent diarrhea and severe abdominal cramps and may be associated with the passage of blood and mucus. Stool cultures for Clostridium difficile and stool assay for C. difficile toxin may be helpful diagnostically.

Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibiotic drug clinically effective against C. difficile colitis.

**ADVERSE REACTIONS**

Clinical Studies Experience

Because clinical trials are conducted under prescribed conditions, adverse reactions rates observed in the clinical trial may not reflect the rates observed in practice. Because clinical trials are also conducted under widely varying conditions, adverse reactions observed in the clinical trials of a drug cannot always be directly compared to rates in the clinical trials of another drug. The adverse reaction information from clinical trials does, however, provide a basis for identifying the adverse reactions that appear to be related to drug use and for approximating rates.

The following selected adverse reactions occurred in less than 0.2% of patients treated with ACANYA Gel: application site pain (0.1%); application site excoriation (0.1%); and application site irritation (0.4%).

During clinical trials, patients were assessed for local cutaneous signs and symptoms of erythema, scaling, itching, burning and stinging. Most local skin reactions increased and peaked around week 4 and continually decreased over time reaching near baseline levels by week 12. The percentage of patients that had symptoms present before treatment, at the maximum value recorded during treatment, and the percent with symptoms present at week 12 are shown below.

<table>
<thead>
<tr>
<th>Local Skin Reactions—Percent Patients with Symptoms Present. Combined Results from the Two Phase 3 Trials (N = 773)</th>
</tr>
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<tbody>
<tr>
<td>Before Treatment (Baseline)</td>
</tr>
<tr>
<td><strong>Erythema</strong></td>
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<tr>
<td>22</td>
</tr>
<tr>
<td>Scaling</td>
</tr>
<tr>
<td>Itching</td>
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<tr>
<td>Burning</td>
</tr>
<tr>
<td>Stinging</td>
</tr>
</tbody>
</table>

*Moderate*

**DRUG INTERACTIONS**

**Erythromycin**

ACANYA Gel should not be used in combination with topical or oral erythromycin-containing products due to its clindamycin component. In vitro studies have shown antagonism between erythromycin and clindamycin. The clinical significance of this in vitro antagonism is not known.

**Concomitant Topical Medications**

Concomitant topical acne therapy should be used with caution because a possible cumulative irritant effect may occur, especially with the use of peeling, desquamating, or abrasive agents.

**Neuromuscular Blocking Agents**

Clindamycin has been shown to have neuromuscular blocking properties that may enhance the action of other neuromuscular blocking agents. Therefore, ACANYA Gel should be used with caution in patients receiving such agents.

**USE IN SPECIFIC POPULATIONS**

**Pregnancy Category C**

There are no well-controlled trials in pregnant women treated with ACANYA Gel. It also is not known whether ACANYA Gel can cause fetal harm when administered to a pregnant woman. ACANYA Gel should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Animal reproductive/developmental toxicity studies have not been conducted with ACANYA Gel or benzoyl peroxide. Developmental toxicity studies of clindamycin performed in rats and mice using oral doses of up to 900 mg/kg/day (240 and 120 times amount of clindamycin in the highest recommended adult human dose based on mg/m², respectively) or subcutaneous doses of up to 200 mg/kg/day (80 and 40 times the amount of clindamycin in the highest recommended adult human dose based on mg/m², respectively) revealed no evidence of teratogenicity.

Nursing Mothers: It is not known whether clindamycin is excreted in human milk after topical application of ACANYA Gel. However, orally and parenterally administered clindamycin has been reported to appear in breast milk. Because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to use ACANYA Gel while nursing, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness of ACANYA Gel in pediatric patients under the age of 12 have not been evaluated. Clinical trials of ACANYA Gel included patients 12-17 years of age.

**Geriatric Use**

Clinical studies of ACANYA Gel did not include sufficient numbers of patients aged 65 and older to determine whether they respond differently from younger patients.

**NONCLINICAL TOXICOLOGY**

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

Carcinogenicity, mutagenicity and impairment of fertility testing of ACANYA Gel have not been performed.

Benzoyl peroxide has been shown to be a tumor promoter and progression agent in a number of animal studies. Benzoyl peroxide at doses of 5 and 10 mg administered topically twice per week for 20 weeks induced skin tumors in transgenic Tg.AC mice. The clinical significance of this is unknown.

Carcinogenicity studies have been conducted with a gel formulation containing 1% clindamycin and 5% benzoyl peroxide. In a 2-year dermal carcinogenicity study in mice and rats followed by 12 weeks of observation, the gel formulation at doses of 900, 2700, and 15000 mg/kg/day (1.8, 5.4, and 30 times amount of clindamycin and 3.6, 10.8, and 60 times amount of benzoyl peroxide in the highest recommended adult human dose of 2.5 g ACANYA Gel based on mg/m², respectively) did not cause any increase in tumors. However, topical treatment with a different gel formulation containing 1% clindamycin and 5% benzoyl peroxide at doses of 100, 500, and 2000 mg/kg/day caused a dose-dependent increase in the incidence of keratoacanthoma at the treated skin site of male rats in a 2-year dermal carcinogenicity study in rats. In an oral (gavage) carcinogenicity study in rats, treatment with the gel formulation at doses of 300, 900 and 3000 mg/kg/day (1.2, 3.6, and 12 times amount of clindamycin and 2.4, 7.2, and 24 times amount of benzoyl peroxide in the highest recommended adult human dose of 2.5 g ACANYA Gel based on mg/m², respectively) for up to 97 weeks did not cause any increase in tumors. In a 52-week dermal photocarcinogenicity study in hairless mice, (40 weeks of treatment followed by 12 weeks of observation), the median time to onset of skin tumor formation decreased and the number of tumors per mouse increased relative to controls following chronic concurrent topical administration of the higher concentration benzoyl peroxide formulation (500 and 10000 mg/kg/day, 5 days/week) and exposure to ultraviolet radiation.

Clindamycin phosphate has not genotoxic in the human lymphocyte chromosome aberration assay. Benzoyl peroxide has been found to cause DNA strand breaks in V79 Chinese hamster ovary cells.

Fertility studies have not been performed with ACANYA Gel or benzoyl peroxide, but fertility and mating ability have been studied with clindamycin. Fertility studies in rats treated orally with up to 300 mg/kg/day of clindamycin (approximately 120 times the amount of clindamycin in the highest recommended adult human dose of 2.5 g ACANYA Gel based on mg/m²) revealed no effects on fertility or mating.

**HOW SUPPLIED**

ACANYA Gel is supplied as a 50 g pump (NDC 13548-132-50).

**Dispensing instructions for the pharmacist**

Dispense ACANYA Gel with a 10 week expiration date.

**Specify** “Store at room temperature up to 25°C (77°F). Do not freeze.”

**Storage and Handling**

**PHARMACIST:** Prior to dispensing, store in a refrigerator, 2°C to 8°C (36°F to 46°F).

**PATIENT:** Store at room temperature or at below 25°C (77°F).

**Protect from freezing.**

**Keep out of the reach of children.**

**Keep container tightly closed.**

**RX Only**

Distributed by CORIA Laboratories, a division of Valeant Pharmaceuticals North America, Fort Worth, TX 76107

Manufactured by Contract Pharmaceuticals Limited Niagara, Buffalo, NY 14213

© 2010 CORIA Laboratories
Is use of a single vial of botulinum toxin for multiple patients safe?

**Q&A**

**DR. VAN VOORHEES:** What are the current recommendations from the Centers for Disease Control and Prevention (CDC) regarding reconstitution and storage of botulinum toxin type A? Are these recommendations different from those recommended by the Centers for Medicare and Medicaid Services (CMS)?

**DR. OZOG:** One of the problems that led to our study is that the CDC guidelines differ from Medicare’s. The CDC insists on adherence to the package insert, which includes the labeling “single patient use.” Their rationale developed from some non-dermatologic cases where patients developed infections including hepatitis after multiple patients were injected from various single-use vials. It wasn’t a problem with the vials themselves but with “double-dipping” of needles, where the same needles were used for multiple patients, which isn’t a safe practice in any situation. Dermatologists have safely used multiple use vials, such as lidocaine, for years without issue when adhering to safe, sterile practice. There is no actual safety difference between using a lidocaine vial for multiple patients and using a botulinum toxin vial for multiple patients.

The issue for hospitals, such as Henry Ford where I practice, is that adherence to and compliance with CDC guidelines is necessary for Joint Commission accreditation. So many hospital-based practices are required to discard large quantities of unused toxin after a single patient use, which is adding to the cost of treating patients. Interestingly, CMS encourages the use of botulinum toxin for multiple patients. They’re paying for it in certain circumstances, including hyperhidrosis and neurological conditions, and they’ll reimburse the exact amount used. However, if there’s remaining toxin they’ll reimburse for that as well. But they’d rather not, and they recognize, correctly we believe, that as long as you’re doing safe practices, using sterile needles and...
not double-dipping, there is no increased risk of infection.

**DR. VAN VOORHEES:** How was this study conducted? Who was surveyed?

**DR. OZOG:** We looked at 1,000 physicians who are members of the American Society for Dermatologic Surgery; we chose this group because its members were likely to be highly procedurally based given the nature of the organization. We sent out Internet-based surveys to 1,000 physicians and had a nice response rate of about 52 percent. We ended up using about 31 percent because we had a 1 percent drop-off based on the initial question, “Do you currently use botulinum toxin in your practice?” 10 people dropped out of the survey based on saying they did not.

**DR. VAN VOORHEES:** What did you ask?

**DR. OZOG:** We asked them how they reconstitute their botulinum toxin in their office, how long they keep the vial after reconstitution, whether they were adhering to the CDC guidelines and discarding after a single use or using a vial for multiple uses, if they’d had a patient develop a local infection after a botulinum toxin injection, and how many years they’ve been in practice. We wanted to see if there were differences in practice patterns based on the length of time since residency.

**DR. VAN VOORHEES:** What did you find? Were most physicians discarding their reconstituted botulinum toxin after one week? What were the majority actually doing?

**DR. OZOG:** The majority of the physicians, more than 68 percent, routinely keep the toxins for one week or greater, and 67 percent felt that the toxins could be safely kept for one to four weeks. No instances of local infection were documented at any time by any of the 312 practices that responded. In fact, we were unable to find any published reports of local infection after botulinum toxin injection.

**DR. VAN VOORHEES:** Were physicians reconstituting their botulinum toxin primarily in sterile saline? If not, what were most using and why?

**DR. OZOG:** Just under 80 percent were using bacteriostatic saline. Some were still using sterile water as per the package insert guidelines, and a few were using non-bacteriostatic saline.

**DR. VAN VOORHEES:** Did you ask them why they were choosing different vehicles to reconstitute the product?

**DR. OZOG:** We didn’t specifically ask them why but the support for using bacteriostatic saline stems from what was originally anecdotal evidence, but then in 2002 Murad Alam, MD, Jeffrey Dover, MD, and Ken Arndt, MD, did a randomized prospective study and 100 percent of patients in their prospective arm had less pain with the bacteriostatic saline and the difference was more than 50 percent in terms of decrease in pain. (Arch Dermatol. 2002;138:510-514.) They posited, and this was borne out in subsequent studies, that the presence of benzyl alcohol not only acts as a preservative but also a temporary anesthetic.

**DR. VAN VOORHEES:** Is there any applicability with other toxins?

**DR. OZOG:** This would be the same between abobotulinum toxin and onabotulinum toxin. We don’t know if incobotulinum toxin will be any different because it’s non-refrigerated, has a smaller particle size, and can be stored for longer periods of time; therefore it is best not to make conclusions until more data is available.

**DR. VAN VOORHEES:** Is the hope that the CDC will revise its guidelines based on these new consensus guidelines?

**DR. OZOG:** That would be hoping for too much. I’m hoping that at least a few of the hospital-based systems, such as Henry Ford, can stand up to the regulatory agencies and point out the evidence. However, in general they tend to be very averse to doing anything other than what the Joint Commission dictates. But perhaps after reviewing our data and getting the bill for all of the toxin that’s been thrown away, they’ll reconsider.

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**DR. OZOG** is an assistant professor in the department of dermatology, division of Mohs micrographic surgery at Henry Ford Hospital. His article was published online in the Journal of the American Academy of Dermatology on Nov. 7, 2011 and is available at www.eblue.org/article/S0190-9622(11)01092-9/fulltext. doi:10.1016/j.jaad.2011.10.008.
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A Passion for Dermatology
Crisis management: Planning for a systems crash

With increasing regulations, decreasing reimbursements, meaningful use compliance, and a host of clinical and operational issues to contemplate, the last thing a practice administrator wants to think about is planning for a systems crash. Yet, this is exactly what is mandated by various data security provisions of both HIPAA and the HITECH law passed as part of 2009’s stimulus package. The two requirements below apply to physician practices:

- 164.308(a)(7)(i) Standard: Contingency plan. Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information.
- 164.308(a)(7)(ii) Implementation specifications: (A) Data backup plan (Required). Establish and implement procedures to create and maintain retrievable exact copies of electronic protected health information. (B) Disaster recovery plan (Required). Establish (and implement as needed) procedures to restore any loss of data.

Disaster planning

A full organizational disaster or business continuity plan would include planning for events that could force the total or partial closure of a medical facility, such as a fire or flood. This column focuses on a single component of that comprehensive plan — planning for a systems crash in key clinical or operational systems that would adversely affect the smooth and effective delivery of vital patient services. Additionally, it is not
sufficient just to have a plan. To be in compliance with HIPAA, the plan must be documented as a set of written policies and procedures.

**ANALYSIS OF A SYSTEMS CRASH**

A systems crash is basically a dramatic term for a systems failure; the most critical impact of a systems failure is that key systems are not accessible in the usual and customary manner by the doctors, medical staff, and patients (if applicable). Therefore, the defining feature of a “crash” is really the inaccessibility of the key programs or data, regardless of why they are inaccessible.

Systems can fail or become inaccessible in many ways. The most obvious failure is a failure of a key hardware component of the computers or related infrastructure (network switches, routers, etc.) on which the systems operate. But there are a number of other failures which can cause systems to be inaccessible, including:

- The operating system of a server hosting key programs or data could become corrupt causing the server not to boot up. Computer viruses and rootkits (which can be used by hackers to install and run malware) are two ways a server operating system can become corrupt.
- The database itself in which the data is stored can become corrupt or the data can become inconsistent (i.e., different and conflicting versions of the same data appear in different places). Data in a database can be inadvertently updated with erroneous transactions or updated with poorly written update programs. Computer viruses can also damage data and index tables inside a database.
- Many medical facilities use systems that are hosted on remote servers not located inside their facility. Any multi-location practice must, by definition, have at least one location which connects remotely to a central location hosting the servers. These connections to remotely hosted servers are generally achieved via a VPN (virtual private network) over the Internet or some other type of dedicated telecommunications network, possibly a point-to-point T1 or a multiprotocol label switching (MPLS) cloud. Any failure or downtime of the Internet or telecommunications circuits, either at the remote site or the central location, will cause systems at a central location to be inaccessible via remote access. A communications failure at the remote site will take just that one site down while a communications failure at the main site will affect all remote sites and is thus much more serious.
- All systems are powered via the regional electrical grid. The recent power outages on the East Coast caused by Hurricane Irene are an example of how power outages can take a system down. Parts of Connecticut were without power for an entire week! Even if a medical practice had its systems hosted in sunny Florida, that practice would have had no Internet service to support its remote connection. Of course the practice is probably not able to open its doors or see patients if it has no electricity, but what if there is a patient emergency and the doctor has to view the electronic health records to provide emergency care?

**PLANNING FOR THE INEVITABLE**

Planning for a system failure requires implementing different solutions to address each of the possible causes of a systems crash. It is worth noting that in the majority of the causes for system inaccessibility described above, having a usable data backup would not be of any help at all. Data backups (assuming they are usable, which is a major assumption not tested frequently enough in real life) are only useful to resolve data corruption. Many of the causes of inaccessibility described above stem from external factors.

**Internet backup:** For many smaller practices, their lifeline to their medical records is probably the Internet connection in their office, which enables the practice to connect to its EHR system remotely hosted usually either by a local hospital or in a data center rented by the EHR software company. The simplest way to avoid a common outage is to install a second Internet connection using a different connection technology. So if the practice currently uses a cable modem, install a Verizon FIOS line or a DSL line. With proper configuration, the second Internet line can serve not only as a standby failover line but can actually provide supplemental bandwidth when both connections are working.

**Anti-virus (AV) software:** AV software on all servers and workstations is an absolute requirement to avoid a crash. It is critical not only to install the software but to keep the software current with updated software versions and anti-virus definitions. Virus developers are a notoriously crafty and creative group. Even with updated systems, viruses can still sneak in with varying impact. Before installing a new
AV system, make sure to test the system on just a few workstations or servers. AV software can adversely affect performance and frequently the configuration must be refined by setting excluded files and folders.

**Back-up power source:** Electrical outages come in varying scope, from a momentary outage to interruptions of days or even weeks. Even a momentary outage can cause servers to shut down in an abrupt manner, leaving the operating system and database in a potentially unstable state. No amount of protection short of self-power generation (as used by hospitals) will protect against this. Reasonable precautions for small practices include plugging all servers into a battery-backed Uninterruptable Power Supply (UPS), which can provide immediate power to a system for at least five minutes and can send a signal to the attached servers to shut down in a graceful manner if power is not restored within a specified time duration. Note that a surge strip does not provide an acceptable level of protection. A UPS can be purchased online or in most office-supply and electronics stores.

**Data backup:** Finally, a situation we have all probably found ourselves in is wishing we had a good current backup. There are many ways to create a backup, from simply making a copy of a data file or program directory onto some local hard disk or USB drive to storing multiple versions of these copies at timed intervals both on location and at one or more secure remote off-site facilities. (To learn more about different backup possibilities, visit www.aad.org/dw for an online-only bonus sidebar to this column.)

**COMMUNICATIONS**

Another key element of crisis management is communications. How the response to a crash is managed, and the status of the recovery process communicated to the users of the system, is vital to restoring confidence in the system.

While it is usually not possible to cover up a systems crash, I have observed a tendency with technical staff to minimize the impact of system interruptions and understate the amount of time it will take to resolve a system failure. Managing the expectations of the users of the system and communicating accurate estimates as to when the systems will be restored will provide a good deal of comfort to otherwise harried medical staff. It may be possible for medical staff to work around the system or implement pre-planned system-down workflows, but the anticipated amount of downtime dictates what the appropriate reaction should be.

**TESTING AND PRACTICE**

The final key element of crisis management and planning for a systems crash is to test all of the recovery and failover solutions and to practice putting the recovery plans into action. Testing should be done frequently with testing methods and schedules that make sense for each recovery scenario. For example, the only way to test if the failover Internet line really fails over in a timely and seamless manner is to disconnect the primary circuit.

The only fool-proof way to test a disaster recovery plan is to simulate the disaster in all its gory details with a full systems shutdown along with full failover and then total recovery back to original systems. This true fail-over/fail-back test requires down time and staff time and this is not a concept that doctors want to consider with a waiting room full of patients. Yet this is truly the only way to simulate a real-life potential system crash.

It is important that plans to update existing systems or install new systems include the appropriate updates to the system disaster recovery plans. The testing process may also reveal aspects of the recovery plans which are out of date and must therefore be revised.

**CONCLUSION**

It’s not possible to predict every possible event which can lead to a systems crash or to systems becoming inaccessible. But it is possible to plan responses to many events which can reasonably be foreseen based on the technology behind the systems and history. A medical practice should not expect to avoid all possible disasters, but with proper planning, documentation, testing, and practice, a medical practice can ensure it will be able to rapidly respond to the crisis and make its systems accessible to physicians and staff in the fastest possible manner to avoid any lapse in service to its patients. dw
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BRIEF SUMMARY

INDICATIONS AND USAGE

EPIDUO Gel is a combination of adapalene, a retinoid, and benzoyl peroxide, and is indicated for the topical treatment of acne vulgaris in patients 12 years of age and older.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

Ultraviolet Light and Environmental Exposure: Avoid exposure to sunlight and sunlamps. Wear sunscreen when sun exposure cannot be avoided. Erythema, scaling, dryness, and stinging/burning may occur with use of EPIDUO Gel.

ADVERSE REACTIONS

Observed local adverse reactions in patients treated with EPIDUO Gel were erythema, scaling, dryness, stinging, and burning. Other than commonly reported adverse events (≥1%) in patients treated with EPIDUO Gel were dry skin, contact dermatitis, application site burning, application site irritation, skin irritation.

DRUG INTERACTIONS

Exercise caution in using preparations containing sulfur, resorcinol, or salicylic acid, medicated or abrasive soaps and cleansers, and products with high concentrations of alcohol or astringents in combination with EPIDUO Gel. Comcomitant use of topical products with a strong drying effect can increase irritation. Use with caution.

Pregnancy

Pregnancy Category C. There are no well-controlled trials in pregnant women treated with EPIDUO Gel. Animal reproduction studies have not been conducted with the combination gel or benzoyl peroxide. Furthermore, such studies are not always predictive of human response; therefore, EPIDUO Gel should be used during pregnancy only if the potential benefit justifies the risk to the fetus.

No teratogenic effects were observed in rats treated with oral doses of 0.15 to 5.0 mg adapalene/kg/day, up to 25 times (mg/m²/day) the maximum recommended human dose (MRHD) of 2 mg of EPIDUO Gel. However, teratogenic changes were observed in rats and rabbits when treated with oral doses of 25 mg adapalene/kg/day representing 123 and 246 times MRHD, respectively. Findings included cleft palate, microphthalmia, encephalocele and skeletal abnormalities in rats; and umbilical hernia, exophthalmos and kidney and skeletal abnormalities in rabbits. Dermal teratology studies conducted in rats and rabbits at doses of 0.65-6.0 mg adapalene/kg/day (25-59 times mg/m²) the MRHD exhibited no fetotoxicity and only minimal increases in supernumerary ribs in both species and delayed ossification in rabbits.

Nursing Mothers

It is not known whether adapalene or benzoyl peroxide is excreted in human milk following use of EPIDUO Gel. Because many drugs are excreted in human milk, caution should be exercised when EPIDUO Gel is administered to a nursing woman.

Pediatric Use

Safety and effectiveness of EPIDUO Gel in pediatric patients under the age of 12 have not been established.

Geriatric Use

Clinical studies of EPIDUO Gel did not include sufficient numbers of subjects aged 65 and older to determine whether they respond differently from younger subjects.

Carcinogenesis, Mutagenesis, Impairment of Fertility

No carcinogenicity, photocarcinogenicity, genotoxicity, or fertility studies were conducted with EPIDUO Gel.

Carcinogenicity studies with adapalene have been conducted in mice at topical doses of 0.4, 1.3, and 4.0 mg/kg/day (1.2, 3.9, and 12 mg/m²/day), and in rats at oral doses of 0.15, 0.5, and 1.5 mg/kg/day (0.5, 3.0, and 9.0 mg/m²/day). In terms of body surface area, the highest dose levels are 9.6 (mice) and 7.4 times (rats) the MRHD of 2 grams of EPIDUO Gel. In the rat study, an increased incidence of benign and malignant pheochromocytomas in the adrenal medulla of male rats was observed. No significant increase in tumor formation was observed in rodents topicaly treated with 15-25% benzoyl peroxide carbopol gel (6-10 times the concentration of benzoyl peroxide in EPIDUO Gel) for two years. Rats received maximum daily applications of 138 (males) and 205 (females) mg benzoyl peroxide/kg. In terms of body surface area, these levels are 27-40 times the MRHD. Similar results were obtained in mice topicaly treated with 25% benzoyl peroxide carbopol gel for 56 weeks following intermittent treatment with 15% benzoyl peroxide carbopol gel for rest of the 2 years study period, and mice topicaly treated with 5% benzoyl peroxide carbopol gel for two years. The role of benzoyl peroxide as a tumor promoter has been well established in several animal species. However, the significance of this finding in humans is unknown.

In a photocarcinogenicity study conducted with 5% benzoyl peroxide carbopol gel, no increase in UV-induced tumor formation was observed in hairless mice topicaly treated for 40 weeks. No photocarcinogenicity studies were conducted with adapalene. However, animal studies have shown an increased tumorigenic risk with the use of pharmacologically similar drugs (e.g., retinoids) when exposed to UV irradiation in the laboratory or sunlight. Although the significance of these findings to humans is not clear, patients should be advised to avoid or minimize exposure to either sunlight or artificial irradiation sources.

Adapalene did not exhibit mutagenic or genotoxic effects in vitro (Ames test, Chinese hamster ovary cell assay, mouse lymphoma TK assay) or in vivo (mouse micronucleus test). Bacterial mutagenicity assays (Ames test) with benzoyl peroxide has provided mixed results, mutagenic potential was observed in a few but not in a majority of investigations. Benzoyl peroxide has been shown to produce single-strand DNA breaks in human bronchial epithelial and mouse epidermal cells, it has caused DNA-protein cross-links in the human cells, and has also induced a dose-dependent increase in sister chromatid exchanges in Chinese hamster ovary cells.

In rat oral studies, 20 mg adapalene/kg/day (58 times the MRHD based on mg/m²/day comparison) did not affect the reproductive performance and fertility of F0 males and females, or growth, development and reproductive function of F1 offspring.

No fertility studies were conducted with benzoyl peroxide.

PATIENT COUNSELING INFORMATION

- Advise patients to cleanse the area to be treated with a mild or soapless cleanser; pat dry. Apply EPIDUO Gel as a thin layer, avoiding the eyes, lips and mucous membranes.
- Advise patients not to use more than the recommended amount and not to apply more than once daily as this will not produce faster results, but may increase irritation.
- EPIDUO Gel may cause irritation such as erythema, scaling, dryness, stinging or burning.
- Advise patients to minimize exposure to sunlight, including sunlamps. Recommend the use of sunscreen products and protective apparel, (e.g., hat) when exposure cannot be avoided.
- EPIDUO Gel may bleach hair and colored fabric.

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Committed to the future of dermatology
Complying with the law while treating patients with special needs

DERMATOLOGY PRACTICE World tackles issues "in Practice" for dermatologists. This month Rachna Chaudhari, the Academy’s practice management manager, offers tips on an area she commonly receives questions about from members.

BY RACHNA CHAUDHARI

Dermatology practices are increasingly faced with complying with new or changing laws and regulations. It can be a constant challenge to follow these issues and ensure compliance. Some of the most common questions the Academy’s practice management staff receive involve how practices should comply with the complex rules regarding patients with special needs. Below are answers to some of the most commonly asked questions.

What laws should my practice be aware of regarding patients with special needs?
There are two laws that affect how your practice should treat patients with special needs: the Americans With Disabilities Act (ADA) and Title VI of the 1964 Civil Rights Act. The ADA is a federal law that prohibits discrimination on the basis of disability. A disability is defined as “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.” Thus,
A dermatology practice cannot refuse to see a patient simply due to their disability if they accept any payment from Medicare or Medicaid.

Title VI of the 1964 Civil Rights Act, another federal law, prohibits discrimination based on national origin. The Department of Health and Human Services (HHS) has expanded this definition to include patients with limited English proficiency (LEP). Thus, providers who accept Medicare or Medicaid payments must abide by the regulations and provide translation services to LEP patients. However, if your practice only accepts Medicare Part B payment, you do not have to abide by this regulation.

What types of services should I offer to comply with the ADA?
The ADA requires practices to accommodate patients with disabilities — which includes not only providing interpreter services, if necessary, but providing patients with access to your physical office building. Analyze your office space to ensure that patients in wheelchairs are able to enter the premises through a ramp or wider doors. Restrooms should be equipped with handicapped stalls and handicapped parking spaces should be available. For a helpful checklist on how to comply with these standards, visit www.ada.gov/checkweb.htm.

In addition to ensuring that your physical practice space can accommodate patients with disabilities, you must insure that staff can communicate with the patient. It is the practice’s responsibility to provide interpreter services for the patient free of charge. Although the ADA does not provide specific guidance on interpreter services, physicians have been found legally liable in cases where they did not offer and pay for interpreter services for patients with hearing or speech disabilities. (To read about one such instance, visit www.ama-assn.org/amednews/2009/01/05/prca0105.htm.) HHS has stated that physicians can use a variety of tools at their disposal to communicate with disabled patients including using handwritten notes to communicate with deaf patients or using telephonic translation services. Medicare will not reimburse you for any interpreter services. However, some insurance contracts will reimburse for these services; investigate this option through each carrier.

Is my practice required to offer interpreter services to limited English proficiency patients?
Your practice is expected to voluntarily comply and offer interpreters services to LEP patients. HHS understands that small practices may not have the resources of larger hospital-based systems and therefore allows greater flexibility in their compliance. The agency states “there is no ‘one size fits all’ solution for Title VI compliance with respect to LEP persons, and what constitutes ‘reasonable steps’ for large providers may not be reasonable where small providers are concerned.” However, practices are expected to provide vital documents such as consent forms or treatment authorization forms in a manner in which patients can fully understand what they are authorizing. Providers can use patients’ family members to aid with translation services as well. However, if the patient is unable to abide by this request, the practice must determine a viable solution at no charge to the patient.

Can the practice collect any additional fees from the patient if the charges for the interpreter services are more than the charges for the visit?
No, the practice cannot collect any additional fees from the patient. Unfortunately, if the cost of the interpreter services is more than the charges for the visit itself, the provider has no recourse for collecting additional payment. Additionally, the provider cannot dismiss the patient from their practice for this reason. Neither Title VI nor the ADA allow practices to dismiss patients on the basis of their disability or limited language proficiency. dw
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GETTING YOUR DUCKS IN A ROW FOR THE RAC

Preparation, balanced approach key for passing unscathed through process
Since its 2006 creation by Congress and attention-grabbing demonstration period shortly thereafter, the Recovery Audit Contractors (RAC) program has been a source of stress for physicians of all stripes. In an era of increasing government oversight over the health care field, the thought of getting caught up in a system charged with recovering billions of health care dollars is enough to unsettle any practitioner. But, according to those with expertise in the RAC audit process, putting the right processes and safeguards in place can ensure that any brush with a RAC audit is at worst a minor one.

**UNDERSTANDING THE PROCESS**

The RAC program was created to help the Centers for Medicare and Medicaid Services (CMS) tamp down the rising costs of improper payments made through Medicare. After early demonstrations that CMS considered successful, Congress made the system permanent effective January 2010. Under the program, independent contractors scour payments to identify and recoup improper payments made to providers of services to Medicare beneficiaries. They may pursue recoupment of funds in instances of incorrect payment amounts, non-covered services, incorrect coding, and duplicate services.
Physicians are subject to two different types of audits — automated reviews and complex, non-automated reviews. The former is triggered automatically through data processing, and is almost always tripped by clearly incorrect coding or misapplication of coding regulations (see sidebar, page 24). The latter utilizes a reviewer, and takes place when there is a high probability of non-covered services or when there is not a clear CMS policy. Both audits review all aspects of supporting records, including E/M codes. Records can be pulled from as far back as October 2007. Physicians who are targeted for audits will receive written notice from a RAC auditor, detailing the incorrectly paid codes and recoupment sought. In the case of automated reviews, the amounts are often small, the result of minor coding or system errors. Complex reviews, on the other hand, are triggered by larger or repeated errors in coding, and can have more serious financial consequences for the physician.

The demonstration period alone resulted in more than $900 million in overpayments being repaid to CMS, paving the way for the current permanent system. Each of the four regional RACs are paid on a contingency fee basis, which costs the government approximately 20 cents for each dollar recovered. While the vast majority of funds recovered come from inpatient facilities, RAC audits can and do happen to private practice physicians with regularity. With a flat-lined economy and shrinking state and federal budgets, RAC audits offer the government a cheap source of revenue, and are likely to continue to increase in regularity for the foreseeable future, according to practice consultant group Fi-Med Management. The key to weathering the storm, according to former dermatology practice manager Joseph Faber, MBA, who now runs Clean Bill of Health LLC and Faber Healthcare Solutions, is to have a grasp of what the RAC audits are looking for and whether the practice is prepared for them.

“The demonstration period alone resulted in more than $900 million in overpayments being repaid to CMS, paving the way for the current permanent system. Each of the four regional RACs are paid on a contingency fee basis, which costs the government approximately 20 cents for each dollar recovered. While the vast majority of funds recovered come from inpatient facilities, RAC audits can and do happen to private practice physicians with regularity. With a flat-lined economy and shrinking state and federal budgets, RAC audits offer the government a cheap source of revenue, and are likely to continue to increase in regularity for the foreseeable future, according to practice consultant group Fi-Med Management. The low cost to CMS and high profitability for RAC auditors has made it an attractive proposition for both of those entities. In addition, the Academy recently received notification that automated RAC audits in different regions have requested monetary recoupment within 30 days for Mohs surgical cases if the pathology was reported by another physician. There have also been reports of requests for recoupment for new patient services when reported with another procedure. (The Academy created resources to help members respond to such audits; see sidebar, p. 23.)

The key to weathering the storm, according to former dermatology practice manager Joseph Faber, MBA, who now runs Clean Bill of Health LLC and Faber Healthcare Solutions, is to have a grasp of what the RAC audits are looking for and whether the practice is prepared for them.

“If one is unprepared, one is almost guaranteed to lose money when the process takes abash of their practice. Not everybody is going to be receiving a full-blown RAC audit, but pretty much everyone will receive a recoupment request or inquiry,” Faber said. “If you don’t respond properly and in a timely fashion, you’ve lost. You’ve accepted their judgment. Accepting the process and knowing how to deal with it is vital to protecting your revenue — or in extreme cases your ability to stay open.”

Further, Faber said, it’s important to recognize and deal with the feelings of one’s practice or credibility being under siege.

“At the very least, there’s an emotional toll taken. Any of the staff that deals with the billing, but especially the physicians that own it, feel like they’re under assault,” he said. “The RAC process was not set up to get anybody, but rather to ensure that Medicare spending is controlled. But it doesn’t mean that physicians don’t feel that way. They often, and understandably, feel that they’re under the gun from insurance carriers in general.”

For physician practitioners feeling outgunned and intimidated by an audit notice, American Academy of Dermatology vice-president Suzanne Connolly, MD, recommends using the

GETTING YOUR DUCKS IN A ROW FOR THE RAC

Not everybody is going to be receiving a full-blown RAC audit, but pretty much everyone will receive a recoupment request or inquiry.

INSURING AGAINST AUDITS

Aside from overpayment recoupments alone, the cost to mount an audit defense can quickly add up when considering record assembly, staff time, and legal fees. For an increasing number of physicians, audit insurance can help alleviate the sting from a lengthy audit process.

While policies vary, most cover audits by both government and private entities, and given the recent scrutiny providers have been under from both private insurers and Medicare, the coverage has become far more popular than in recent decades. Policies that used to cost tens of thousands of dollars per year can now be purchased for a couple thousand.

Even so, physicians in the market for audit insurance need to understand what is and isn’t covered under individual policies, which can vary greatly between carriers. Some, for instance, will cover the cost of regulatory actions, while others will not. And among carriers, provisions for exclusions and attorneys’ costs are far from uniform.
organization’s RAC audit toolkit as a guidebook toward successfully handling the process (see sidebar below). Even beforehand, she said, it’s vital to come to terms with the possibility of an audit and prepare a plan for that eventualty.

“You need to have a very process-oriented response in place. It’s important to know what your next steps should be when you receive notice of an audit,” Dr. Connolly said. “There are some very time-sensitive deadlines you need to know how to meet. At the dermatology meetings I attend, there’s the sense that a growing number of physicians want to know more detail about what’s involved in the RAC process.”

AUDIT PLANNING
In planning for an audit, according to California dermatologist Allan Wirtzer, MD, who has spoken frequently on coding and practice management at the Academy’s Annual Meeting, it’s important to have a baseline grasp of the importance of thorough documentation to support one’s coding.

“The most important thing a dermatologist can do [to be prepared for an audit — or to avoid one] is just make sure that they’re comfortable with the requirements for the different CPT codes and modifiers. The biggest concern based on experience is the significant number of physicians who still aren’t entirely comfortable with documentation requirements,” Dr. Wirtzer said.

“One thing they can do is look at the CPT book and read through the different portions that can guide them into the use of these, as well as avail themselves of the support of their professional societies.” (Dermatology World offers a monthly column on coding and documentation issues, “Cracking the Code;” see p. 6. Previous columns are available online at www.aad.org/dw.)

Prior to an audit, Faber said, practices that use electronic practice management or electronic health record (EHR) systems can avail themselves of some of the software’s built-in safeguards.

“You can set up your billing system to make sure that it checks the diagnosis code against the sex of the patient, for example. You could set it to trigger a query in the office. Some of them can be set for intra-lesional injections, biopsies, or excisions. It will flag a file that shows procedures above a certain quantity and ask you to check your notes and make sure it’s correct,” Faber said. “Some of the EHR systems will assist you with the coding. They will only provide the code for the procedure after the service has been documented. Assuming the physician is documenting it correctly, there’s a degree of protection there.”

In addition to having the correct documentation and processes in place, Faber said, it’s important to determine the practice’s standard responses to RAC inquiries and determine who in the practice will be responsible for each of those responses. The rapid timeline of the RAC process, he said, makes this virtually a requirement.

“There should be a point person who handles those inquiries, is educated in the appeals process, and who can respond to those claims in a timely fashion. Believe it or not, you’ve got 45 days to respond to a RAC inquiry, and that clock starts the day they mail their letter,” Faber said. “Missing that deadline means losing money.”

To make sure one’s documentation and staff is prepared for an audit, one can run a mock audit, either in-house or through a coding and reimbursement consultant. This will serve to accurately test the vital procedures needed during an audit period and ascertain the RAC team’s functionality.

RESPONDING TO AN AUDIT
Once a RAC audit is triggered, Faber said, the value of thorough documentation is revealed. This, he said, not only applies to the records and claims in question, but the practice’s replies to every step of the inquiry.

“Everything must be responded to in writing, copies of everything need to be kept, and your responses all need to be sent via certified mail with a return receipt,” he said. “You want to prove what you sent and when you sent it. That team manager, the RAC coordinator, needs to have an audit log that keeps track of every step of this process.”

At the outset of the RAC audit process, according to Dr. Wirtzer, it’s important for the physician to take the time to review all charts before the staff sends them to the RAC.

“The staff should never send the charts out before the physician has a chance to look at them. There is an opportunity, if there’s something the doctor is aware was left out, to make an addendum, as long as that addendum is dated appropriately. It’s possible to add a note to a chart saying ‘in review, I see that I did not include this bit of information,’ as long as they use the proper date,” Dr. Wirtzer said. “Make clarifications prior to sending it

AAD RAC RESOURCES
In response to member needs, the American Academy of Dermatology has created the RAC Audit Survival Toolkit, which offers expert advice from the Coding and Reimbursement Task Force and practice management staff. It features information on the most frequently asked questions from dermatologists in an easily navigable Q and A format, a thorough background on the RAC audit process, and contact information for the Academy’s expert practice management staff.

“The RAC Audit Survival Toolkit gives very specific information on how to go about handling every step of a RAC audit,” said Academy Vice President Suzanne Connolly, MD. “This was developed in response to the stress upon members who were receiving notices of audits. Surviving a RAC audit is a matter of following certain steps in order to deal with the situation. The toolkit gives you exactly what you need to know.”

out, but never alter the record in such a way that it’s not properly dated. It will be assumed that the physician is trying to cover up errors and possibly make fraudulent notations.”

Further, Dr. Wirtzer said, during a RAC audit is an unfortunate time to realize that one’s records are illegible or incomplete.

“Make sure that your records are legible. In many cases, especially when doctors aren’t using any kind of transcription or computerized system, the handwritten notes tend to be really limited and hard to discern,” he said. “I’ve had a chance to do some records reviews in the past, and illegible medical records may actually give the impression to an auditor that material isn’t there that very well may be, but they can’t read it.”

Another important consideration of the process is that every practice makes the occasional mistake in coding, and may receive an overpayment — or even underpayment — of a virtually insignificant amount. In this case, it’s important to weigh staff time or physician time versus the amount of the RAC claim. According to Dr. Wirtzer, claims are occasionally made over dozens of payments that total no more than $10, making the decision clear. Ultimately, he said, each practice has to decide the level at which they will choose to mount an appeal. The important part, he said, is not to be intimidated by the process or feel bullied into accepting the RAC’s decision.

“I frankly feel that any claims that are not clearly the result of incorrect coding should be appealed. It’s my feeling that many of the companies rely on the intimidating aspect of the process to keep physicians from appealing,” he said. “Of the RAC audits that have been challenged by those colleagues I know, the majority of them has resulted in significant reduction of any repayments. Utilize available resources from the AAD and, if so disposed, from attorneys to aggressively challenge any demands for repayments. You’ll likely win the majority of contested claims if your documentation is there and there aren’t flagrant errors in coding.”

Should a practice decide to appeal, Faber said, it’s important to know the audience for the appeal and respond properly.

“What’s interesting is when you file an appeal, it’s not reviewed by the RAC, it’s reviewed by an administrative law judge, who can be far more sympathetic to your cause than the RAC will be,” Faber said. “If you’ve already got a system in place to show that you’ve identified particular weaknesses and are taking steps to prevent them from reoccurring, you’ve got an improved chance of winning an appeal because you’re demonstrating that your practice is proactive.”

The appeals process, according to Dr. Wirtzer and Faber, can take over a year’s time to work through the system. Even then, they said, there is no guarantee of success. But, they said, one should measure the success of one’s preparation not only on the outcome, but by the practice’s ability to respond to the process with copious and accurate documentation in an efficient and clearly defined process.

“Bear in mind that the appeals process may be expensive. There’s staff time, there are records to search, there’s copies and postage, legal counsel that may be needed in higher-end cases. Depending on how extensive the audit is, it can take a year or two,” Faber said. “And even after everything involved, it may be lost anyway, so a decision has to be made whether to fight or pay on a case-by-case basis. But you need to know exactly how you’re going to handle the process when — not if — an inquiry comes in.”

**HAIR TRIGGERS**

Joseph Faber, MBA, president of Clean Bill of Health, LLC, advises his clients on a number of measures to make sure that easily corrected coding mistakes don’t trigger RAC audits. The following, he said, are the most common.

- **Obvious coding errors:** “Genital warts have separate codes based on the type of destruction and whether the patient is male or female. If you code a female destruction on a 38-year-old male, that can trigger an audit. It should be caught by the office, the clear- inghouse, and the insurance carrier, but sometimes those things slip through.”

- **Unnecessary or non-covered treatments.**

- **An office visit within the global period of a procedure.**

- **Incorrect settings:** “Providing a hospital visit in an office or vice-versa can provide a trigger.”

- **Rendering a CLIA service in a non-CLIA-authorized setting:** “For instance, being paid for a potassium hydroxide fungal slide in an office that doesn’t have a CLIA cert. Or doing a pregnancy test on a non-isotretinoin patient without a CLIA certification.”

- **Excessive units:** “Sometimes it’s a normative case, and the chart notes would prove it was a necessary series of treatments, but it’s unusual at the levels that trigger an audit. If somebody comes into the office and has seven biopsies, that’s going to stand out. It may be that there are seven different sites that got biopsied, they could be completely covered in suspicious nevi, but the documentation is going to need to support that. Most people don’t have that number of biopsies done in a visit.”
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Empty promises

Cosmetic tax fails to raise expected revenue in New Jersey, Connecticut starts down similar path

BY RUTH CAROL, CONTRIBUTING WRITER
Expect to see a handful of states propose cosmetic procedure taxes this year as they scramble to balance their budgets. Whether these states will choose to learn from New Jersey’s experience, which led to the law there being repealed by a nearly unanimous vote last month, or take Connecticut’s lead to implement one is anybody’s guess.

“States will continue to look at a cosmetic procedure tax because they view it as an easy, quick fix,” said Kathryn Chandra, assistant director of state policy for the American Academy of Dermatology Association. “But once state legislators and regulators realize the complexity of implementing and enforcing such a tax, coupled with patient privacy concerns and determining what is medically necessary or cosmetic, it becomes much less attractive.”

Among the states that considered imposing a cosmetic procedure tax in recent years but decided against it are Arkansas, Illinois, New York, and Tennessee. Last year, efforts to pass a tax on cosmetic procedures in Minnesota, Texas, and Washington failed. Despite significant opposition in Connecticut, a 6.35 percent tax went into effect in July.

NEW JERSEY’S JOURNEY
New Jersey’s tax, imposed in 2004, has fallen significantly short of raising the anticipated $24 million in annual revenues. It yielded only $7.8 million in 2005 and $10.8 million the following year while being applied to such procedures as hair transplants, cosmetic injections, cosmetic soft tissue fillers, dermabrasion and chemical peel, laser hair removal, laser skin resurfacing, laser treatment of leg veins, and sclerotherapy. A loss of indirect state taxes due to patients having cosmetic procedures performed in neighboring states without a tax is estimated at an additional $26.4 million, according to the Jasos Group, an Orlando, Fla.-based health care consulting firm. That means for every $1 New Jersey collects on the tax, the state loses $3.39 in total revenue. >>
Empty promises

For patients who live in some parts of New Jersey, all they have to do is cross a bridge to get to New York, Pennsylvania, or Delaware to have cosmetic procedures that are not taxed, noted Sandra Vause, MD, president of the Dermatological Society of New Jersey (DSNJ). Rod Kaufmann, MD, who practices in Princeton, which is 30 minutes from the Pennsylvania border, hasn’t been significantly impacted by the tax because he doesn’t perform a lot of expensive cosmetic procedures. But some of his colleagues who perform such procedures as liposuction have been negatively affected. “I try to keep business in my community. This tax drives business not only out of the community, but out of the state,” he added.

Enforcement of the tax has been problematic because it involves performing audits of medical practices to determine whether procedures were cosmetic or reconstructive. The review of patient records violates patient privacy and confidentiality, per HIPAA regulations. These records not only contain personal information, such as test and screening results, major illnesses and surgeries, medications, chronic conditions, and a family history of illnesses, but frequently include photographs of the patient, Dr. Vause pointed out.

Because the tax does not clearly define cosmetic procedures, the decision of medical necessity is left up to tax auditors.

PATIENT CARE AFFECTED

Even more worrisome to dermatologists is that tax auditors lack the medical knowledge to distinguish between cosmetic and constructive procedures. For example, laser treatment and sclerotherapy are used to treat spider veins and varicose veins, the latter of which cause pain, dermatitis, ulceration, and swelling. Dr. Vause explained. If used for spider veins, they are considered cosmetic procedures and therefore subject to the tax. However, if they are deemed medically necessary for the treatment of varicose veins, which commonly have connected spider veins, they should not be taxed. But because the tax does not clearly define cosmetic procedures, the decision of medical necessity is left up to tax auditors, she said. “The physician and patient should be making that decision, not legislators or tax auditors.”

Other cosmetic surgeries that could potentially be taxed are those following reconstructive surgery to improve the appearance of accident victims, laser resurfacing to smooth a disfiguring facial scar resulting from skin cancer surgery, and treatment of HIV-associated facial lipoatrophy.

The tax also raises patient safety concerns. “Everybody is looking for a better deal in this economy. Patients go to a neighboring state for laser hair removal treatments, for example, and come back to us when they get burnt,” Dr. Vause said. “It happens a lot.”

Additionally, the tax undermines the dermatologists’ ability to provide continuity of care. “You can’t take care of the patients the way you want to if they are going elsewhere for some procedures,” Dr. Kaufmann added.

NOT JUST WEALTHY WOMEN

When introduced, the tax was considered a sin tax affecting primarily wealthy people, noted Dr. Kaufmann, who serves on the DSNJ’s Board of Directors and a coalition of New Jersey medical professionals who sought to repeal the tax. “But it impacts patients from all walks

ACADEMY OFFERS MEMBERS HELP IN FIGHT AGAINST COSMETIC PROCEDURE TAXES

Dermatologists who want to join the effort to repeal cosmetic procedure taxes, or prevent one from being passed in their state, can turn to the Academy for help. The Academy’s online Advocacy Toolkit, available at www.aad.org/member-tools-and-benefits/aada-advocacy/state-affairs/advocacy-toolkit, provides members with the facts regarding cosmetic medical procedure taxes, as well as documents for use in meeting with state legislators about the issue. Templates for communicating with the media about the issue are also available.
of life, not just the upper class,” he said. Patients seeking cosmetic procedures include secretaries, teachers, and nurses. According to the American Society of Plastic Surgeons, 71 percent of individuals seeking plastic surgery earned less than $60,000 a year. Only 10 percent of respondents reported a household income of more than $90,000.

Additionally, women are unfairly burdened by this tax, Dr. Vause noted. According to a survey conducted by the American Society for Dermatologic Surgery, women comprise 83 percent of its members’ minimally invasive cosmetic medical procedure patients.

All of these reasons were cited for years by supporters of the bill signed into law by Gov. Chris Christie (R) on Jan. 17. The law immediately reduced the 6 percent tax by 2 percentage points, with an additional 2 point drop coming July 1 before the tax is finally phased out completely on July 1, 2013. The bill’s sponsor, Assemblyman Gordon Johnson, cited the tax as having imposed “increased overall costs for recipients of cosmetic medical procedures” as well as “an administrative burden on the medical offices billing the procedures and the state agencies charged with the administration and enforcement of the tax.” In 2007, former Gov. Jon Corzine (D) had vetoed a similar tax repeal bill that was unanimously passed by the state legislature.

CONNECTICUT’S TAX
In nearby Connecticut, despite strong opposition by the Connecticut Dermatology and Dermatologic Surgery Society, the State Medical Society, the Connecticut Society of Plastic and Reconstructive Surgeons, and other medical specialty groups, the state passed a cosmetic procedure tax last May. Even the state’s Commissioner of Revenue Services, Kevin Sullivan, has publically stated that the tax would be virtually Impossible to regulate, noted Debbie Osborn, executive director of the Connecticut Dermatology and Dermatologic Surgery Society.

The tax is expected to generate $4.1 million in fiscal year 2012 and $4.3 million in 2013. However, according
to the Jasos Group, Connecticut may lose an estimated $6.6 million in corporate income tax and an additional $7.2 million in indirect state taxes due to “surgical flight” losses, based on New Jersey’s experience.

“Our society knew from the get-go that it would be a difficult issue to win, first because the deficit was so large in Connecticut and second because we had a Democratic majority in both houses and a newly elected Democratic governor who vowed to reduce the deficit and warned that no one would be spared,” Osborn said.

On a positive note, the new law excludes reconstructive surgery, defined as “any surgery performed on abnormal structures caused by or related to congenital defects, developmental abnormalities, trauma, infection, tumors or disease, including procedures to improve function or give a more normal appearance.” So even though the law says that botulinum toxin injections should be taxed, if the physician determines that it is a medically necessary treatment, as in the case of neurological conditions, the cosmetic tax will not apply. “We are still working closely with the Department of Revenue to codify better regulations on this tax,” she added.

**NEXT STEPS**
The Connecticut Dermatology and Dermatologic Surgery Society plans to survey dermatologists this July, one year after the tax was imposed, to determine its impact on them, Osborn said. “The burden is on us to prove that the tax is a hardship for dermatologists,” she said, adding, “The first time a doctor gets audited, our society will be involved to insure that there are no violations to the HIPAA laws or that no information regarding patient privacy is violated by the state.”

Connecticut is already considered one of the worst states in which to practice medicine due to high medical liability premiums and strong managed care lobbyists who prevent effective standards-in-contracting legislation which would help balance out the managed care contracts and make them fairer to the providers, Osborn noted. This tax will contribute further to the decline of dermatologists practicing in the state, she predicted.

The dermatology community must take a proactive stance regarding cosmetic procedure taxes to prevent them from being passed when they are proposed in various states across the country, Dr. Vause said. She encouraged dermatologists interested in legal issues to get involved on state boards and panels to give a voice to dermatologists on such matters.

Additionally, AADA members can access resources through the online state advocacy toolkit on the AAD website, www.aad.org/member-tools-and-benefits/aada-advocacy/state-affairs/advocacy-toolkit, or contact the AADA Government Affairs department. (See sidebar, p. 28, for more information.) “The AADA has worked collaboratively with the American Society for Dermatologic Surgery, the American Society of Plastic Surgeons, the American Medical Association, and many others to oppose cosmetic medical procedure taxes,” Chandra said. “Together, the Stop Medical Taxes Coalition has developed numerous resources and background materials that explain why this is not a good option to raise state revenue.”

Meanwhile, Osborn hopes that the Connecticut General Assembly will take a page out of New Jersey’s book and reconsider its cosmetic procedure tax. “Many times due to time restraints with regard to legislative deadlines, legislation is pushed through the process without thorough investigation on the long-term implications of a bill. In this case, New Jersey discovered that their neighboring states, such as New York, gained considerable advantage with the passage of a cosmetic tax. Fortunately, the General Assembly acknowledges its miscalculation,” she said. “Time will tell if Connecticut has made the same miscalculation on realized revenue from a cosmetic tax. My guess is that Connecticut has and New York will be the real winner at the end of the tournament.” 

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The Stop Medical Taxes coalition has developed materials that explain why this is not a good option to raise state revenue.
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ATTACKING ACTINIC KERATOSSES

Multiple modalities let dermatologists tailor treatment to the patient.
It is the second most common diagnosis made by dermatologists (after acne vulgaris), actinic keratosis (AK) is a condition virtually every practicing dermatologist will encounter frequently. Yet despite its prevalence, a number of questions about the condition and its treatment remain unresolved. What percentage of Americans will develop AKs? Is AK a precursor to non-melanoma skin cancer, or is it a malignancy in the earliest stages? What are the optimal treatment strategies? Is it ever appropriate to leave an AK lesion untreated?

“This is a huge health care problem in the U.S. We just don’t have enough data to understand how big a problem it is,” said Abrar Qureshi, MD, MPH, assistant professor of dermatology at Harvard Medical School. An estimate from 2005’s Burden of Skin Diseases report, prepared by The Lewin Group for the American Academy of Dermatology Association and the Society for Investigative Dermatology, put the age-adjusted prevalence for AK in the U.S. at 6.5 percent but noted that “AKs are very common among adults ages 60 to 69, with 83 percent of men and 64 percent of women having at least one lesion.”

Also in question is the rate at which AKs progress to invasive squamous cell carcinoma (SCC). A Journal of the American Academy of Dermatology study examining the dermatoscopic features of AK (in press; see sidebar) found that published estimates of the risk of progression of AK to invasive SCC for individual lesions ranged from 0.1 percent to 20 percent.

IS IT CANCER?
The lack of data regarding AK extends to the issue of whether AKs are precursor lesions or early malignancies, Dr. Qureshi said. “The data is not clear on the level of risk involved with leaving some AKs untreated. Some associated risk has been proven, but we haven’t quantified that risk.” A common method of assessing the risk is to conduct retrospective reviews of the records of patients with AKs who went on to develop skin cancer. However, Dr. Qureshi pointed out that “people who get treated for AKs, which result from sun damage, are people who are likely to get skin cancer anyway. The question is, how many of the cancers that arose were AKs first?” Dr. Qureshi said he considers AKs to be premalignant, “but there is a school of thought out there among dermatopathologists and dermatologists that AKs are cancer. It’s a very fine line.”
Two dermatologists who addressed the controversy in *Cutis* (2011;87(4):201-7) concluded that there is insufficient evidence to support the concept that AK is frank squamous cell carcinoma (SCC). However, the authors maintained that the risk for progression of AK to invasive SCC provides the rationale for treatment, an approach recommended by several dermatologists with expertise in treating non-melanoma skin cancer.

“I think the bottom line is that it’s largely a semantic difference,” said Steven R. Feldman, MD, PhD, professor of dermatology, pathology, and public health sciences at Wake Forest University School of Medicine and a co-author of the *Cutis* study. “You can call them skin cancers in an early stage or you can call them pre-cancerous lesions. Either way, they should be treated.”

**LESION-DIRECTED VS. FIELD TREATMENT**

Another area under question is the appropriate way to treat AKs. With a broad range of modalities available, dermatologists need to consider not just their own preferences but also those of the patient, experts say. “We don’t have a great treatment that does everything we want it to do,” said Mary E. Maloney, MD, chief of the division of dermatology at the University of Massachusetts Medical School. “We need to be creative and use all of our modalities to try to fit them to the patient rather than fit the patient to our favorite modality.” In addition to the number, features, and location of the AK lesions, factors such as the patient’s age, history of sun exposure, prior AKs, prior skin cancer, and immunosuppression help shape the treatment plan. Economic considerations can also have an impact, both in terms of cost to the patient and reimbursement for the physician.

Dermatologists first must determine whether the treatment regimen will involve destruction of AK lesions as they arise (lesion-directed or “spot” therapy), treatment of a broader field of disease with topical agents or photodynamic therapy (PDT), or a combination of both approaches. Cryotherapy with liquid nitrogen is the most common destructive therapy, although electrodessication and curettage is sometimes used to treat thick, hyperkeratotic AKs. Topical agents commonly used for field therapy include 5-fluorouracil (5-FU), imiquimod, and diclofenac gel. Both approaches have proven effective in achieving at least temporary clearance of AKs, and both involve some discomfort, redness, and blistering at the treatment site.

“I think the treatment of AK is somewhat problematic in that there are lots of ways to skin a cat, and lots of compliance issues,” Dr. Maloney said. “It’s absolutely easiest for patients to come in, have a liquid nitrogen treatment, and go home and not have to do anything else. As we move away from that modality, success is much more dependent on a patient being compliant with the treatment regimens. It’s totally ineffective if the patient doesn’t do it.” Other dermatologists point to the belief that field treatment attacks subclinical AKs and may reduce the need for future therapy. “With spot therapy, in my opinion, you’re chasing your tail,” Dr. Qureshi said. “It’s perfectly reasonable to destroy isolated lesions. But I’m talking about the patient who’s had multiple AKs and multiple freezings, had severe dermatoheliosis. You can keep destroying these lesions for months or years. I feel there are patients who are getting spot therapy who should be getting field therapy.”

**CRYOTHERAPY A MAINSTAY**

The popularity of cryotherapy for AKs among dermatologists was demonstrated in a study co-authored by Dr. Feldman and published in the *Journal of Dermatological Treatment* (2006;17(3):162-166). The authors examined the records of 1,743 patients treated for AK and surveyed 293 dermatologists and 241 non-dermatologist physicians who treat AK. Nearly three-quarters of the patients received cryotherapy only, while 16 percent received topical therapy only, and fewer than 10 percent received both treatments. Dermatologists were three times more likely to use cryotherapy than non-dermatologists.

“Patients in the study indicated a preference for drug treatment rather than cryotherapy, although in real life, when they see the cost of the drug they often opt for the procedure,” Dr. Feldman said. The physician reimbursement structure favors the office-based procedure, and many patients’ insurance policies make the cryotherapy procedure less costly than a course of drug treatment, Dr. Feldman said. “I want to give my patients the best care, irrespective of what I’m being paid. And the real issue that comes up in my practice is that I will think it’s in the patient’s best interest to have a topical therapy for many thin lesions,
and they will come back and say no, go ahead and do the procedure because the cream costs too much.”

The experts were in broad agreement that cryotherapy is most appropriate for fewer lesions and those that are particularly thick or hyperkeratotic. Short-term effects can include blistering and redness; longer term, hypopigmentation may occur. “It’s very time-efficient and cost-efficient for the dermatologist, but it’s only treating the visible lesions and it’s not a 100 percent cure; there can be persistence or a recurrence at the treatment site,” said James Q. Del Rosso, DO, dermatology residency program director at Valley Hospital Medical Center in Las Vegas, and a private practitioner of dermatology and dermatologic surgery at Las Vegas Skin and Cancer Clinics. “A lot of factors affect the outcomes after cryotherapy: how long you spray the liquid nitrogen, how far away the spray tip is held from the lesion, the caliber of the tip used, and how much is being delivered. The longer you spray it, the more reaction you’re going to get, and the more likely you are to get more severe blistering or complications such as hypopigmentation.” Dr. Maloney concurred, remarking that the success of cryotherapy depends on “if you’re willing to freeze vigorously. A very light freeze may not be terribly effective. With a very vigorous double freeze-thaw cycle, success is much better, but one must recognize

**NEW RESEARCH ON THE DIAGNOSIS AND TREATMENT OF ACTINIC KERATOSES**

Recently published research examines the dermoscopic features of non-melanoma skin cancer and highlights new techniques in the use of photodynamic therapy (PDT) to treat actinic keratosis (AK).

Noting that the differentiation of early AK lesions on clinical grounds alone can be difficult, a group of physicians from Austria, Australia, and Italy sought to elaborate dermoscopic features that can help distinguish AK, intraepidermal carcinoma (IEC), and invasive squamous cell carcinoma (SCC). Their analysis of 243 tumors, published in the *Journal of the American Academy of Dermatology* (in press), found that the majority of facial AKs exhibited a red pseudonetwork (“strawberry”) pattern. This pseudonetwork was rarely seen in IEC and invasive SCC lesions, which tended to show increased vascularity and signs of keratinization. The authors propose, describe, and illustrate a progression model of facial AK developing into IEC and invasive SCC, and hypothesize that dermoscopy reveals a red starburst pattern in lesions undergoing a dynamic period of progression.

Several investigators are exploring the combination of two treatment modalities for AK, together or in sequence, in search of a synergistic effect. In a study published in the *Journal of Drugs in Dermatology* (2011;10(10):1124-1132), Barry Galitzer, MD, tested the effect of pretreatment with tazarotene cream on the outcomes of 10 patients treated with PDT for AK lesions of the hand and forearm. One dorsal hand or forearm was pretreated with tazarotene gel 0.1 percent twice a day for one week before irradiation with blue light PDT; the other hand or arm was not pretreated. Lesion counts on the treatment area at baseline and eight weeks following treatment suggested that pretreatment with tazarotene may have slightly enhanced the efficacy of the PDT. Tolerability was similar between the two groups except for significantly more erythema in the tazarotene-treated arm five minutes after PDT.

A group of 31 researchers tested the safety and efficacy of a new formulation of 5-aminolevulinic acid (ALA) in PDT. The new agent, BF–200 ALA, is a gel formulation with nanoemulsion which overcomes previous problems of ALA instability and improves skin penetration. Results of the phase III study, a randomized trial of 600 patients, will be published in the *British Journal of Dermatology*. Compared with a registered methyl-ALA cream (MAL) and placebo, the patient complete clearance rates 12 weeks after the last PDT were 78.2 percent for BF–200 ALA, 64.2 percent for MAL, and 17.1 percent for placebo.
the increased risk for erosion and scar with the more vigorous freeze.”

TOPICAL THERAPIES, PDT PROVIDE OPTIONS

For patients with multiple AKs and extensive sun damage, field treatment with a topical agent or PDT may be the most cost-effective and efficacious approach to therapy. The oldest topical remedy for AKs still in use, 5-FU prevents cell proliferation and leads to selective cell death. Imiquimod, approved by the U.S. Food and Drug Administration in 1997, activates immune cells through the toll-like receptor 7. Diclofenac gel is a nonsteroidal anti-inflammatory drug, approved by the FDA in 2000. It selectively inhibits cyclooxygenase and potentially acts through the induction of apoptosis, inhibition of angiogenesis, and up-regulation of the arachidonic pathway, according to a study of its therapeutic potential in the *International Journal of Dermatology* (2001;40(11):709-713).

When faced with a choice among the topical agents, patients often express a preference based on the length of the course of treatment, level of discomfort, and the appearance of their skin, dermatologists said. “The 5-FU almost always causes a vigorous reaction, and patients usually do not prefer to use it on the face,” said Dr. Qureshi. “You use it once or twice a day for about two weeks. Typically, it’s cheaper to use on large body areas like the chest, arms, and back. And then on the face, I’ll often use imiquimod at once-a-week frequency so they get the benefit without the reaction — you don’t get that redness and crusting at once a week. But, the duration of treatment is 12 to 16 weeks.” A newer formulation of imiquimod may provide a treatment regimen that is easier for patients to follow, according to William Huang, MD, MPH, assistant professor of dermatology at Wake Forest University School of Medicine. “The original formulation of imiquimod was a 5 percent cream that was FDA approved to treat actinic keratoses when used twice a week for 16 weeks. This prolonged course can lead to challenges in patient adherence to the medication in addition to the discomfort of the treatment itself. A newer 3.75 percent cream formulation of imiquimod has a somewhat easier regimen to follow. The medication is used nightly for two weeks, then off the medication for two weeks, then on again nightly for two weeks. Many patients find this a more convenient dosing schedule.”

Dr. Del Rosso said that although many physicians prefer 5-FU because they have more experience with it, both imiquimod and diclofenac gel “appear to have greater long-term benefit in clearing AKs in many patients as compared to 5-FU, based on the data that is available thus far.” A long-term follow-up study of diclofenac sodium 3 percent gel treatment, published in the *Journal of Clinical Aesthetic Dermatology* (2009;27(2):20-5), found that one year after treatment of AK lesions, 79 percent of patients had 100 percent clearance of target lesions, and 91 percent of patients had 75 percent clearance of target lesions. A randomized study comparing three AK treatments, published in the *British Journal of Dermatology* (2007;157 Suppl 2:34-40), found that after one year, the sustained clearance rate of initially cleared individual lesions was 28 percent for cryosurgery, 54 percent for 5-FU, and 73 percent for imiquimod.

“Imiquimod has proven, sustained, long-term benefit in terms of reducing the number of lesions — both the initial lesions that were there in the beginning and new lesions developing in the field of treatment,” Dr. Del Rosso said. “Diclofenac gel also has some proven sustained benefit in the area of treatment. The longer recommended treatment course with topical diclofenac is twice daily application for three months, but the amount of visible redness and inflammation is, in the majority of patients, significantly less. Most of these patients don’t have any downtime, they just have to treat over a longer period of time.”

A third topical agent, ingenol mebutate gel, is currently in Phase III testing for the treatment of AK lesions. Derived from the sap of the plant Euphorbia peplus, the treatment regimen is only two or three days. A study published by a group of Australian physicians in *JAAD* (2011;Nov 4 Epub) suggested a dual mechanism of action: rapid lesion necrosis and specific neutrophil-mediated, antibody-dependent cellular toxicity. “Reaction occurs over a period of a week to a couple of weeks,” said Dr. Del Rosso, who was not an investigator in the clinical studies of ingenol mebutate, but has reviewed results and photographs from several of the studies evaluating this agent for treatment of AKs. “Some discomfort and some inflammation is to be expected at least in some patients, although most appear to tolerate the therapy.
well. It’s been studied in a variety of locations: face, scalp, trunk, and extremities.”

Photodynamic therapy for AK can be conducted with either 5-aminolevulinic acid (ALA) plus blue light, or methyl-ALA plus red light. Daniel Pearce, MD, assistant professor of dermatology at Wake Forest University School of Medicine, is using blue light PDT on a trial basis. “One thing I’ve seen in my practice this past year is that folks will come in with a desire to do something different,” he said. “They’ve tried all the topicals, they all have decent efficacies, but anyone with a chronic, visible disease is always looking for something better.” One distinct advantage is compliance, Dr. Pearce said. “I really like the idea that they come in, they get incubated, they’re treated. You don’t have to depend on them to put something on their sore, weeping face for the next two weeks.” A disadvantage to patients is time spent in the office: 60 to 90 minutes for incubation plus the 16-minute treatment. “Also, you have to avoid all UV light exposure for 48 hours after treatment, and that’s a difficulty for people. You can’t just use sunscreen,” Dr. Pearce said. Although long-term studies have not compared the clearance rate for PDT with those of topical agents, Dr. Pearce said the clearance rate after a course of treatment (two PDT treatments three weeks apart) is comparable to that of other modalities. (See sidebar, p. 35, for research on new techniques for treating AK with PDT.)

BEST OF BOTH WORLDS

For many patients, the optimal approach to treatment involves both lesion-directed and field-based therapy. Sequential therapy with cryosurgery followed by PDT is “a great way to go,” Dr. Pearce said. “Because PDT doesn’t do especially well with the thicker spots, you may choose to ablate them at your first evaluation with the cryosurgery, and then you leave the more subtle, lower-grade AKs for the field-based treatment at a later date with the PDT.”

Dr. Qureshi takes a similar approach in following cryotherapy with a topical agent, in the belief that “a combination of therapies is probably the best strategy to get your patients clear and prevent cancer.”

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We all know that there are many changes that will occur in our environment that will have dramatic impacts on dermatology. These changes include decreasing Medicare and insurance reimbursements, a decreasing number of trained dermatologists, increasing wait times to see a dermatologist, increasing numbers of non-dermatologists practicing dermatology, increasing numbers of physician assistants and nurse practitioners practicing dermatology, a decrease in dermatology research funding, an increase in other specialists who may try promote themselves and criticize dermatologists, and a decrease in support from industry which will require an increase in financial support by us members. Is our specialty prepared for all these changes?

“Change before you have to,” Jack Welch said. But change is difficult. I am proud to say that our AAD Board of Directors recently voted to consider implementing dramatic changes in communications as well as advocacy and government affairs in anticipation of the harsh realities that are in our future. Can we be more effective in both these areas? We have appointed a Task Force on Transforming Communications chaired by Roger Cell- ley, MD, with members including Patricia Farris, MD, Pearl Grimes, MD, Phoebe Rich, MD, Thomas Rohrer, MD, Susan Taylor, MD, and myself; a Task Force on Transforming Advocacy and Government Affairs chaired by Darrell Rigel, MD, with members including Clay J. Cockerell, MD, Lisa A. Garner, MD, David M. Pariser, MD, and Jack S. Resneck Jr., MD; and a Task Force on Office-Based Surgery chaired by C. William Hanke, MD, with members including Bruce Brod, MD, Brett Coldiron, MD, W. Patrick Davey, MD, Zoe D. Draelos, MD, Dirk M. Elston, MD, Lisa A. Garner, MD, Roy C. Grekin, MD, Vincent A. Muscarella, MD, James Spencer, MD, and Michael Zanolli, MD. These three task forces will help determine if we need to update our three-year-old strategic plan to anticipate new changes. Do we need to change how we have been doing things? Are we spending our resources wisely? If we anticipate the coming changes we can shape our specialty’s future.

The Board has already made modest changes in how it functions. We have eliminated some of the perfunctory approvals of reports and information-only items from our meet- ings so we have time to discuss strategic issues that will affect our specialty. Our new secretary treasurer, Suzanne Olbricht, MD, will be asked to prepare for a future of less industry support by reducing spending that is not supportive of our top priorities.

We have raised more money for SkinPAC this year than ever before — yet we have to increase that amount if we are to educate legislators about dermatology issues. This year we have also strengthened our relationships with other specialty organizations, industry; international dermatology organizations, and the FDA. Our executive director and I are scheduled to meet with the president of the American Society of Plastic Surgeons to discuss common interests and differences between plastic surgery and dermatology. We have visited 15 different companies to discuss our common goals and objectives with them. We have been involved in meetings in China and Europe. We have established an excellent relationship between the AAD and the FDA after our cooperative press announcement regarding broad-spectrum sunscreens in June.

We are going to have another great Annual Meeting in San Diego March 16-20, with new sessions on providing patients with an unforgettable positive office visit, late-breaking dermatology research, dilemmas in dermatology, and a course using head prostheses to enhance surgical learning. Dermatology in Action is a new initiative that allows all of us to give back to the cities in which the AAD hosts its scientific meetings. Last year AAD member volunteers helped create an urban garden for a community center in the Lower Ninth Ward of New Orleans. This year we will be painting the interior of a residential center for the homeless in San Diego. Please consider volunteering; sign up by Feb. 13 at www.aad.org/DermatologyInAction.

It has been a fulfilling experience to be president of the AAD this year. I have been impressed by the skills and talents of our staff and member volunteers. We have members and staff who love our specialty and will work their hardest to complete any project. They represent all of us within organized medicine and attend committee meetings to make our specialty of dermatology better. Speaking of dedicated volunteers, I started working with your next president, Dan Siegel, MD, when we were both 18-year-old students in a six-year medical program at Rensselaer Polytechnic Institute. I have worked closely with him again the last several months. The AAD has one of the smartest and prepared presidents ready to take office. Dr. Siegel and I will be available in the AAD’s booth in the exhibit hall in San Diego on March 19 from 1:30 to 2:30 p.m., and I welcome you to stop by and share your thoughts with us.

I would like to thank members of the AAD Executive Office for helping me as president. The person I want to thank the most is my greatest love in the world, my wife Lisa. She allowed me to travel more than 150,000 miles on AAD business and enjoy being your president. Finally, I thank all of you for your contributions to our specialty. Please remember to contribute to the AAD Sustaining Fund and SkinPAC so that our specialty will continue to flourish.
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2012 Academy election opens March 17
THE ACADEMY’S ELECTION SITE, www.aad.org/election, will be accessible starting Tuesday, March 6. This site contains all the candidates’ background materials, the ballot book, and the proposed amendment to the bylaws. The president-elect speeches delivered at the Annual Business Meeting and videotaped candidate statements will be posted to the election site by Tuesday, March 20.

The 2012 AAD election officially opens on March 17 at 12:01 a.m. ET. Eligible voting members of the Academy are urged to cast their votes. Members can conveniently access the Academy election site at www.aad.org/election or use the direct link at https://www.esc-vote.com/aad2012 to vote online.

When voting, you will be asked to provide a secure access code and your AAD member identification number. Access codes will be sent to all eligible voting members on Friday, Feb. 17 via email or mail (for those without email addresses on file).

U.S. POSTAL SERVICE ANNOUNCES DELAYS IN SERVICE
The U.S. Postal Service recently announced the closing of 250 mail processing centers across the country and cuts to first-class mail delivery service. These changes may delay the delivery of the 2012 AAD election ballot packet as well as election ballots submitted by mail. To ensure your vote is received, please view the online AAD election ballot packet and cast your vote at www.aad.org/election.

If you require assistance with your secure access code during the Annual Meeting on Saturday, March 17 or Sunday, March 18, please contact Election Services Corporation (ESC) between 10 a.m. and 6 p.m. ET at their toll free number, (866) 720-4357 or via email at aadhelp@electionservice-scorp.com. After the Annual Meeting, ESC will be available Monday through Friday from 9 a.m. to 5 p.m. ET.

VOTING DEADLINE IS APRIL 16
Paper and online voting concludes for all members on Monday, April 16. Ballots must be received or electronically posted on April 16 by 11:59 p.m. ET.

– JOAN TENUT

The American Academy of Dermatology’s Board of Directors has selected Suzanne Olbricht, MD, of Newton, Mass., to serve as secretary-treasurer.

Dr. Olbricht, who has been the assistant secretary-treasurer since February of 2010, will complete the term of Robert D. Greenberg, MD, who tendered his resignation to the Board effective Dec. 31, 2011. Dr. Olbricht became secretary-treasurer on Jan. 1, 2012 and will serve the AAD in this position through the close of the 2016 Annual Meeting.

The Board decided to allow the normal assistant secretary-treasurer search process to continue as planned. The successful candidate selected by the Board at its May 2012 meeting will immediately assume the responsibilities of interim assistant secretary-treasurer until the 2013 Annual Meeting and then will serve as assistant secretary-treasurer until the close of the 2016 Annual Meeting, at which time that person will be eligible to be selected secretary-treasurer by the Board.

Dr. Olbricht identified specific assistant secretary-treasurer responsibilities that could be delegated to Board members during the period before an interim assistant secretary-treasurer is chosen and parceled them out appropriately.

As secretary-treasurer, Dr. Olbricht will work with the Board of Directors to ensure the ongoing financial health of the Academy, serving on a number of key committees including the Priorities Committee, the Audit Committee, the Development Committee, the Strategy Committee, and others.

“The Academy is an essential resource for dermatologists in their daily practice and I feel privileged to serve the membership in this capacity,” Dr. Olbricht said. – RICHARD NELSON

Suzanne Olbricht, MD, named secretary-treasurer

academy update
Election Period

The Academy election shall open to the membership not more than two (2) days prior to or not more than one (1) business day after the Annual Business Meeting.

Annual Meeting and Other Academy Election Activities

The following election activities shall occur during the Annual Meeting:

a. (1) slated candidates shall be acknowledged at the Annual Business Meeting
   (2) slated candidates for President-Elect shall be given the opportunity to make a five-minute presentation at the Annual Business Meeting (See 13. h.)
   (3) slated candidates shall be given the opportunity to videotape a statement that will be broadcast during the meeting
   (4) slated candidate videotaped statements will be posted to the Academy Website for viewing by the membership throughout the Election Period
   (5) slated candidate electronic Disclosure Statements of Potential Conflict of Interest will be posted to the Academy Website for viewing by the membership
   (6) slated candidates shall receive a ribbon identifying them as a candidate for election
   (7) slated candidate poster boards shall be displayed
   (8) voting members shall be given the opportunity to vote electronically onsite

b. The Academy will make every effort to assure that candidates for office do not receive inadvertent additional publicity through the reporting of Academy activities in official publications or through the day-to-day program or administrative functions in which a candidate may be involved, except that the names of candidates:
   • who are winners of Academy awards may be published in Academy Annual Meeting publications; and
   • that appear in Academy materials having educational content i.e., interviews, articles and publications, will be disseminated to the membership, even if such distribution occurs during the “Election Period”. (See 9) authorized, and recommended election activities identified herein by publishing an excerpt of this administrative regulation on election activities in Dermatology World in the earliest issue after the date that candidates are announced, in any issue which includes candidate position statements, in the issue that is mailed closest to the date on which the ballots are mailed, and by including the summary in the election voting packets.

c. The Academy will inform the membership of the official,
14. Authorized Election Activities by Director Write-in Candidates

a. Unsuccessful nominees who wish to be a Director write-in candidate, have been vetted by the Nominating Committee, and are a Fellow in good standing with the Academy, are required to submit their name in writing to the American Academy of Dermatology, attention Secretary-Treasurer, by a designated date that is ten (10) days prior to the opening of the election.

b. Director Write-in candidates are also subject to the rules outlined in Paragraph 13, b-g.

15. Ballot Return Date

To be valid and in accordance with Paragraph 17 of this administrative regulation ballots:

(a) must be submitted online or sent directly to the independent election service designated therein

(b) must be received or electronically posted by a date designated therein, which date shall be within thirty (30) days after the date ballots are sent to the membership

(c) must not contain write-in votes for Officers and Nominating Committee member representative positions

(d) may contain a vote for one (1) eligible Director write-in candidate

(e) may not exceed four (4) votes for Directors inclusive of one (1) Director write-in candidate

16. Announcement of Election Results

Successful candidates shall be announced as soon as practicable after the ballot return date.

17. Official Election Candidate Results

The official results of each election certified by the independent election service are kept on file at the Academy office. Each candidate may verbally receive the numerical results of the election in which the individual was a candidate by contacting the Secretary-Treasurer.

18. Assumption of Office

Successful candidates shall assume office at the conclusion of the Annual Meeting following the election.

19. Manner of Notice and Announcement

Notice(s) and Announcement(s) required by this administrative regulation shall be in writing and, unless otherwise specified by the Academy Bylaws or this administrative regulation, may be affected by publication in an official Academy or Association publication, by United States mail, or by facsimile, or electronic transmission.

20. Ad Hoc Task Force on Election Oversight

An ad hoc task force will be appointed each year prior to the Call for Nominations, to monitor the Academy’s election process and election activities. The ad hoc task force will be chaired by the Immediate Past President holding office when slated candidates are announced, and will be further comprised of the Secretary-Treasurer or Assistant Secretary-Treasurer, and the following individuals appointed by the President: a past member of the Board of Directors, a past Chair of the Nominating Committee, a member of the Advisory Board, and a previously unsuccessful candidate. Members asked to serve on the AHTF on Election Oversight should not accept the appointment if they anticipate becoming a candidate in the election. Upon acceptance of the AHTF appointment, the member must remain neutral throughout their term, which includes, but is not limited to, the nominating process and Election Period. The AHTF members are restricted from submitting nominations, supporting nominees, writing letters or speaking in support of any nominee, potential candidate, slated candidate or write-in candidate running for office.

The Ad Hoc Task Force on Election Oversight will report any recommendations for sanctions to the Board of Directors. At the end of the election process, the Ad Hoc Task Force will present a formal report to the Board of Directors and include any recommendations that it may have for revisions to existing regulations.

21. Candidate Sanctions for Failure to Comply with Regulations

Slated and write-in candidate(s), who are found, by a majority vote of the Board of Directors, to be in violation of the above regulations may, at the Board’s discretion, be subject to sanctions, including but not limited to, removal from the ballot and/or nullification of votes received.

The Board of Directors retains discretion to alter the dates within this administrative regulation to accommodate special circumstances.
Advisory Board policy resolutions sought

THE AMERICAN ACADEMY OF DERMATOLOGY’S ADVISORY BOARD looks forward to hearing the voices of the Academy’s grassroots through the submission of proposed policy resolutions. The Advisory Board convenes every year to deliberate on issues of importance to individual practitioners, and bring proposed new policies to the Academy’s Board of Directors for consideration.

If there is an issue of interest and/or concern, now is your opportunity to submit a resolution from which an official Academy position might arise. To ensure full consideration, all resolutions must be received by Feb. 24. The author or his/her representative must be present at the Reference Committee Hearing on Friday, March 16 at the Academy’s 70th Annual Meeting in San Diego to introduce and discuss the resolution. The full Advisory Board will vote on resolutions at the General Business Meeting on Sunday, March 18. All resolutions and/or questions regarding the process should be directed to Barbara Greenan, staff liaison to the Advisory Board, at bgreenan@aad.org. – ABIGAIL OSBORNE

Funding available for international volunteer and humanitarian projects

FUNDING IS AVAILABLE THROUGH THE ACADEMY FOR SMALL INTERNATIONAL VOLUNTEER AND HUMANITARIAN PROJECTS. Requests for funding should be submitted online to the Education and Volunteers Abroad Committee, and must demonstrate how the project or activity will:

- support the Academy’s strategic framework, which calls on the organization to increase knowledge generation and sharing throughout the world, improve patient care globally through volunteerism and humanitarian efforts focused on capacity building, and improve access to dermatologic care in underserved areas;
- benefit recipients/beneficiaries; and
- be monitored and evaluated.

Requests will be reviewed by the committee in March, July, and December. For more information, contact Coura Badiane, international affairs specialist, at cbadiane@aad.org or visit www.aad.org/awards-grants-and-scholarships/grants-for-skin-care-in-developing-countries/. – COURA BADIANE

Academy seeks session directors for 71st Annual Meeting

OPPORTUNITIES TO PARTICIPATE IN THE SCIENTIFIC PROGRAM of the American Academy of Dermatology’s 71st Annual Meeting, being held in Miami Beach, Fla., March 1-5, 2013, are available on the Academy’s website. Members who have previously directed a session may apply to direct any type of session; members who would be first-time session directors may apply to direct a focus session.

To learn more about the different session types and to submit an application, visit www.aad.org/faculty/am2013/application/. Applications are due March 16, 2012 and will be reviewed by the Scientific Assembly Committee.

Members with questions may contact the education department via email at speakers@aad.org for additional assistance. – RICHARD NELSON
Erik J. Stratman, MD, named Pearson Award winner

The Academy’s Council on Education and Maintenance of Certification has named Erik J. Stratman, MD, chairman of the department of dermatology at the Marshfield Clinic in Marshfield, Wis., as the 2012 winner of the Thomas G. Pearson, EdD Memorial Education Award. The award, which will be presented at the 70th Annual Meeting in San Diego, was created to recognize dermatologists who demonstrate outstanding commitment to the Academy’s educational efforts through the development and coordination of educational programs.

Dr. Stratman served the Academy as the chairman of the Council on Education from 2007 to 2011, and has also served on the Annual Meeting Evaluation Task Force, Core Curriculum Workgroup, and Maintenance of Certification Committee. He called his time on the Council the most enjoyable dermatology education activity of his career to date.

“I have always been fascinated by the way different people learn in different ways. It is incredibly rewarding to tackle the teaching of a dermatology subject in a new way, and to see the ‘light bulb’ turn on for the learner,” Dr. Stratman said. “As a teacher, it is also very rewarding to know that you have made a positive difference in the way a current or future dermatologist will evaluate or manage their patients in a high quality manner as a direct result of your lessons or pearls.”

Dr. Stratman said that he’s been influenced greatly by Dr. Pearson’s contributions to medical teaching, and hopes to follow his example.

“I am incredibly humbled to share this award with those dermatology education giants who received it before me. Dr. Pearson’s reputation and influence as a medical educator extends well beyond dermatology, as he was well known for his positive contributions in national CME circles as well,” he said. “I hope to continue to make positive contributions in dermatology education and to promote dermatology as a specialty capable and competent to lead other specialties in advancing the national medical education scene.”

Media Highlight

To raise the visibility of dermatology and the range of services that dermatologists provide, members of the American Academy of Dermatology participate in media interviews with both national and local media outlets to assist journalists in developing stories about skin, hair, and nails.

In a recent issue of Allure [circ. 1,108,834], the article “Face Forward” featured a special on the latest evidence-based skin care. Hema Sundaram, MD, Jeanette Graf, MD, Vivian Bucay, MD, Zoe DraeLOS, MD, David McDaniel, MD, Fredric Brandt, MD, Ranella Hirsch, MD, Patricia Wexler, MD, Francesca Fusco, MD, Howard Sobel, MD, Leslie Baumann, MD, and Elizabeth Tanzi, MD, evaluated skin care breakthroughs and ingredient claims. To read this article and other dermatology news, visit the Academy’s online Media Relations Toolkit at www.aad.org/member-tools-and-benefits/media-relations-toolkit. - ROSE PASOWICZ

RAISING FUNDS FOR COMMUNITY HEALTH CARE CAN BE A DIFFICULT PROPOSITION under the most forgiving of circumstances. For Rock Hill, S.C., dermatologist Timothy Woodall, MD, the challenge is to raise those funds in a poor rural community. As a member of the board of the Union County Healthcare Foundation for seven years — six of those as chairman — he has been tasked with raising funds for the hospital district, emergency services, and local nursing homes. Dr. Woodall has spent that time outperforming expectations.

“Serving others like this, it’s what my parents raised me to do.”

• Union County, made up of former mill towns located in the north of the state, consistently struggles with high unemployment; the October 2011 rate reached 16.7 percent. Despite this, Dr. Woodall has managed to raise over $750,000 for county health services during his time heading the foundation’s fundraising.

• “When I was asked to serve on the board, it was a no-brainer. I can raise money for a number of different causes, and it all goes into the community. It makes a lot of sense for me as a physician.”

• One of Dr. Woodall’s largest projects was raising funds for the purchase of a state-of-the-art rescue vehicle, which can transmit EKG data to the local emergency room and is also able to affect a river rescue if necessary.

• Apart from his work with the foundation, Dr. Woodall also undertakes fundraising and volunteerism through his local church. He put on a golf tournament to purchase a water filtration system for a Haitian village stricken with cholera.

• “Every Thanksgiving, my family used to work with local churches to feed the needy. My parents were always very involved with different charity organizations. There was no epiphany, it’s just what I’ve always done, and it’s been immensely satisfying.”

- JOHN CARRUTHERS

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PROFESSIONAL OPPORTUNITIES

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Busy practice in retirement community specializing in skin cancer bx looking for a FT/PT BC/BE derm. Mobs plus. Fax CV to (352) 873-9397 or email skin cancercenter@yahoo.com. www.skincancersurgery.net.

SUNRISE, FLORIDA

WELLESLEY, MA
Board certified or board eligible dermatologist for dynamic, busy practice. Flexible full time or part time. www.kraussderm.com. Email CV to Maureen@kraussderm.com.

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We are seeking a general dermatologist to join a well-established and reputable, private practice. With 7 physicians (including one Mohs surgeon) and 7 mid-levels serving 3 locations and a patient population of 300,000, we offer a team approach to care. The option to practice a variety of cosmetic procedures is available with various lasers at each site. Call is rare. Hours are: M-F with no weekends or evenings. We offer a competitive salary and full benefits including: paid health, vacation, CME time/stipend, licenses/dues, paid malpractice, 401K and profit sharing. Excellent recruitment incentives including: signing bonus, paid moving expenses, student loan repayment, and $30k relocation stipend. Located minutes from Ann Arbor. Visit our web site: www.dermatologyskinsurgerycenter.com. For more information contact: Michelle Spielberg at (800)547-1451 Email: mspielberg@sourceonestl.com.

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As part of our continued growth, we are currently seeking outgoing Dermatologists to join our team in the San Fernando Valley region of Southern California.

Responsibilities: In this role, you will have the opportunity to provide care and support to a wide variety of patients, work in a multi-disciplinary office practice while achieving the work/life balance you’ve been looking for!

Required: Candidates should be Board Certified in Dermatology. Board eligible candidates will also be considered. For immediate consideration please apply online at www.healthcarepartners.com or send to CV to lalvarado@healthcarepartners.com

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For more information, please contact: Glenn Smith, MHA; Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

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For more information, please contact: Glenn Smith, MHA; Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

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WASHINGTON, DC


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Our client, a licensed Physician Assistant with 10 years of experience is starting a private practice in the Merrimack Valley area, northwest of Boston. We are looking for a Massachusetts licensed physician to act as supervisor. The SP will not be required to see patients.

Requirements and Responsibilities:

- Will review and co-sign all new patient charts and patients with Medicare who have a new problem within fourteen days. This may be done electronically.
- Must be available by phone or pager for consultation. If the SP is not available, an alternate physician will be a substitute for a limited time.
- Will agree with and co-sign the start-up practice guidelines and prescription guidelines each year.
- The SP will allow his/her information to be listed on the practice website.
- The SP will co-sign other related documents that may be related to the PA’s license renewal, DEA number and CME conference registration.
- Must be a graduate of a United States accredited medical school and have received a doctor of medicine (MD).
- Must be a member of the American Academy of Dermatology.
- 10 Years of experience in Dermatology.
- Experience working with physicians assistants is preferred.

Please forward cover letter and CV as MS Word doc attachments to: stacyorrick@orrickassoc.com.

Geisinger Health System is looking for full-time or part-time Clinical Dermatologists to join our very active and growing Dermatology Department at Geisinger Medical Center (GMC) in Danville, PA and Geisinger Wyoming Valley (GWW) Medical Center in Wilkes-Barre, PA.

Geisinger’s Dermatology Department offers a friendly, collegial work environment that allows physicians to create a balance between individual practice and resident teaching while pursuing clinical opportunities in specific areas of interest. Research and publication are not required but opportunities abound.

The region boasts exceptional quality of life with a low cost of living and excellent public and private school systems. Our practice sites are surrounded by several universities, offering cultural and athletic events. Both Danville and Wilkes-Barre are within a few hours drive of New York City, Philadelphia and Washington, D.C.

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For more information or to apply for this position, please contact Elaine Tomashik, Professional Staff Recruiter, at 1-800-845-7112 or etomaschik@geisinger.edu.

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EHR SATISFACTION IN DERMATOLOGY

The American Academy of Dermatology’s recent survey of its members regarding their use of electronic health records (EHR) in their practices found that 45.4 percent of respondents (264 of 582) had already implemented an EHR system. With the maximum possible meaningful use bonus payment of $44,000 (paid over five years) available to dermatologists who begin attesting to their use of an EHR system in 2012, those who have not adopted yet may want to consider the experience of those who have as they decide whether the time is right to take the plunge.

The chart below indicates the percentage of the 264 survey respondents who have implemented an EHR system who agreed or disagreed with a series of statements about their satisfaction with it. (Totals do not add up to 100 percent as some respondents gave a neutral response or did not answer.)

For more information about EHR adoption, visit the Academy’s HIT-Kit online at www.aad.org/hitkit. - RICHARD NELSON, MD

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**EHR Satisfaction Survey**

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<th>Statement</th>
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<th>Disagreed</th>
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<tr>
<td>Would not go back to paper-based practice</td>
<td>51.5%</td>
<td>24.2%</td>
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<tr>
<td>Receive helpful software upgrades from vendor</td>
<td>43.5%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Receive timely tech support from vendor</td>
<td>43.6%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Office staff received necessary training from vendor</td>
<td>42.4%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Overall, satisfied with EHR</td>
<td>34.5%</td>
<td>23.7%</td>
</tr>
<tr>
<td>System is intuitive and easy to use</td>
<td>35.6%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Would pick the same vendor again</td>
<td>37.5%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Office productivity improved with EHR</td>
<td>41.7%</td>
<td>25.4%</td>
</tr>
<tr>
<td>EHR will save the practice money</td>
<td>42.4%</td>
<td>24.2%</td>
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