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Another Temporary Medicare Fix

On April 15th, President Obama signed the Continuing Extension Act of 2010. The Act extends through May 31, 2010, the zero percent update to the 2010 Medicare Physician Fee Schedule (MFS) which was in effect for claims with dates of service from Jan. 1, 2010, through March 31, 2010. The law is retroactive to April 1, 2010. The Centers for Medicare & Medicaid Services (CMS) instructed its Medicare contractors to begin processing claims under the new law for services provided by physicians, non-physician practitioners (NPPs) and others paid under the MPFS. Most claims with dates of service April 1 and later have been held by Medicare in anticipation of congressional action.

If Congress had not acted, payment rates for these services by physicians, NPPs and others who are paid under the MPFS would have been reduced by 21.2%, as required by the Sustainable Growth Rate (SGR) formula. This is the third time this year that the negative update has been temporarily delayed. The negative update was originally scheduled to go into effect Jan. 1, 2010. It was postponed until March 1 by a provision in the Defense Appropriations Act of 2009, and again until April 1, in the Temporary Extenders Act of 2010. Logistically, this means that there must also be a longer term bill presented within weeks to resolve the Medicare Fee Schedule as well as one more short term (30 day) extension to accommodate passage of the longer term bill.

The Obama Administration has repeatedly stated that the Sustainable Growth Rate (SGR) formula is broken and needs to be fixed. This is complicated because a proposed 10 year Medicare freeze would cost over $300 billion and would exceed any Congressional "pay as you go" budget exemptions. The reality of the situation is simply another 60 day extension at the 2009 conversion factor rate and the continued possibility that a Congressional failure to act will result in a mid-year drop in Medicare payments.

SGR HISTORY AND BACKGROUND

The Sustainable Growth Rate formula was created in 1997 as a target rate of growth in Medicare Part B spending for physician and non-physician practitioner (nurses, physical therapists, physician assistants, etc.) services. The SGR is used to establish payment updates – one of several factors that set Medicare physician payment rates each year. The SGR formula was designed to bring actual spending in-line with allowable spending over time. It ties increases in the volume of services per Medicare beneficiary to growth in the GDP. Although adjustments are made for changes in law and regulation, these adjustments have not adequately reflected increased services resulting from technological innovation and Medicare benefit expansions (such as cancer screenings, diabetes management, etc.). This has prompted annual payment cuts that were then exacerbated by Congressional actions that stopped the cuts but failed to adjust the target, thereby leading to ever larger projected payment cuts.

The payment update for a year is determined by comparing cumulative actual expenditures to cumulative target expenditures in the prior year. For example, the 2009 payment update was set by comparing actual expenditures from 1996-2008 to targeted expenditures from 1996-2008. If spending exceeds the SGR targets, then the physician payment update is less than the increase in the inflationary cost of providing a service. However, spending includes drugs administered in a physician's office and laboratory tests (actual products), and physician services (set by the fee schedule). Adjusting the payment update ONLY applies to physician services (fee schedule) and not to drugs or lab tests.

It has taken nearly a decade for the Medicare physician payment system to recover from the 5.4% cut imposed due to the SGR in January, 2002. During that time, payment rates fell further and further behind inflation in medical practice costs.

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IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader

Congress has once again waited until the last minute to avoid disaster. On April 15, Congress voted to avert the 21.2% cut in the Medicare physician payment rate. Physicians participating in Medicare will continue to receive payment at the 2009 rate through May 31st, and then we face it all again!

The Senate finally passed H.R. 4851, the Continuing Extension Act of 2010, which extends 2009 payment rates. The House had passed the original measure on March 17, but some Senators objected to its passage because of its designation as an emergency measure (because the bill also included the extension of unemployment benefits) that would not require budgetary offsets.

Your AADA, along with others in the medical community, has taken the firm position that Congress cannot continue to use budget gimmicks and short-term patches. A permanent and comprehensive reform of the Medicare payment formula must be passed to ensure that the Medicare program is sound and that patients will have access to quality dermatologic and other medical care that they need.

AADA is working with House and Senate leadership offices and White House officials on a long-term Sustainable Growth Rate (SGR) solution that will be considered in Congress. Further information about Congressional action on Medicare payment will be made available on the AADA Health System Reform Resource Center.

As you know, Medicare's hold on physician claims officially expired on April 15. While some carriers had the capacity to hold claims for an additional day or two and still meet Medicare law's prompt payment requirements, others began processing claims at the reduced rates. Importantly, claims for services provided on or after April 1 should be processed on a rolling basis, with claims for services provided earliest completed first and later claims held for as long as possible. We expect that retroactive payment adjustments will be made for claims processed at the reduced rate. Expect specific instructions on reprocessing for any claims that were paid at the 21.2% reduction from your Medicare Carrier or Medicare Administrative Contractor (MAC).

Unfortunately, this fix is also temporary. A permanent solution to the ongoing impact of the Sustainable Growth Rate (SGR) on Medicare payment to physicians is still missing.

Best regards,

Norma L. Border, Editor

Vernell St. John Retires

To put it in her own words, Vernell St. John is "Off to see the Wizard!" After sixteen years with the Academy, Vernell and her husband Gary are returning to the Land of OZ (Kansas) where they have family and friends. She always described her position here at AAD as her "dream job" because she enjoyed working with the Academy's members, dermatology residents and practice managers so much.

As staff liaison to our AMA CPT Advisors, Vernell kept the comments on new codes going in on time and built an enviable reputation for her knowledge of dermatology code development. She also served as staff liaison to the Coding & Reimbursement Task Force as well as Assistant Editor for both DermCodingConsult and the AAD Coding & Documentation Manual.

She has been an expert addition to the many Academy education sessions that she has graced as faculty at AAD Annual and Summer meetings. To that must be added the many state and local dermatology societies around the country where she has provided the latest coding updates. She has also served as faculty for the Association of Dermatology Administrators and Managers (ADA/M) as well as the American Academy of Professional Coders (AAPC).

For over a decade, the test of almost any "creative variation" on a dermatologic coding scheme has been the voice of reason saying "Let's fly it past Vernell and see what she thinks." For those of us she leaves behind, she has set an extraordinary example and a very high standard for integrity and service to Academy members.

"It is with gratitude that I say thanks to all of you for enriching my life, " Vernell said and couldn't resist a last coding comment, that "I do not anticipate ICD-9-CM code 309.9 as I will be involved in E000.8." Her retirement date was April 1, 2010.

Editor's Notes:
The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:
Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

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Another Temporary Medicare Fix

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CONGRESSIONAL INTERVENTIONS TO STOP SGR CUTS

Year	Scheduled Rate	Congressional Action
2002	-5.4% cut	None
2003	-4.4% cut	1.6% Increase
2004	-4.5% cut	1.5% increase
2005	-3.3% cut	1.5% increase
2006	-4.4% cut	Freeze at 2005 level
2007	-5% cut	Freeze at 2005 level
2008	-10.1% cut	0.5% increase
2009	-15% cut	1.1% increase
2010	-21% cut	Three implementation delays

REBASING THE SGR – PATH TO PERMANENT REFORM

While recent Medicare legislation has provided temporary relief from SGR cuts, the budgetary situation has been made worse in the long-run by simply moving the cuts to the next year. This has increased the severity of the scheduled cuts and raised the cost of enacting a permanent solution. The only realistic way to start on a path to permanently reform the physician payment system and repeal the SGR is to rebase or reset the baseline to present spending rather than 1996 rates.

The primary purpose of a budget baseline is to provide policy-makers with a clear forecast of projected spending and taxpayer obligations. The current physician payment baseline, based on 1996 expenditure levels, is no longer useful – it paints a false picture of actual Medicare spending. Medical technology, Medicare coverage and benefits, and the cost of running a medical practice have all changed drastically since 1996 yet the SGR has failed to adequately recognize those changes. Congress has ignored the baseline by interceding six times since 2003 to temporarily stop Medicare physician payment cuts. This has created a very large SGR debt burden that is impossible to eliminate if kept on the current path of delaying effective Medicare payment reform to another year. Essentially, by temporarily stopping the SGR cuts through the approach of moving the cuts to future years, Congress has created an enormous "credit card" debt that has no hope of being paid off unless the SGR debt burden is eliminated and the physician payment system is rebased. The longer Congress delays action, the more expensive SGR reform has become.

Coding Update

ADJACENT TISSUE TRANSFER CODES

Two new adjacent tissue transfer codes were added to CPT 2010. Theses codes are:

- 14301 Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
- 14302 each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

Code 14302 is an add-on code to be used with code 14301 when the adjacent tissue transfer is greater than 60 sq cm.

The question was raised about the use of these two new codes for adjacent tissue transfers in separate areas. Should the total defect size of multiple areas be added together?

The Academy requested and received the following clarification from AMA/CPT. Codes 14301 and 14302 would be reported like the other adjacent tissue transfer codes, the appropriate code(s) per site requiring the adjacent tissue transfer repair.

If two or more separate adjacent tissue transfers were performed that were of the size to require the use of add-on code 14302, code 14302 should be reported separately for each flap site, as should the primary code 14301. For example, site A was 90 sq cm and site B was 120 sq cm, having no contiguous borders, would be reported as:

14301
14302 - with 1 unit
14301 - 59
14302 - with 2 units

If the repaired sites had contiguous borders, then the coding would be based on the total primary plus secondary defect size. For purposes of code selection, AMA CPT defines the term "defect" as including the primary and secondary defects. The primary defect resulting from the excision and the secondary defect resulting from the flap design to perform the reconstruction are measured together to determine the total size of the defect and to determine the correct code.

The additional directives in CPT 2010 state that without an additional incision to accomplish the repair, an adjacent tissue transfer code would not be appropriate. For repair of a wound site that requires the use of undermining without that additional incision, the repair would be reported as an intermediate or complex repair. Also remember, that the excision is included in the CPT 14000-14350 code series and is not separately reportable.

TRICARE UPDATES ADD-ON CODE POLICY

Tricare has been contacted to request a policy correction in response to incorrect reimbursement practices for add-on codes. Tricare modified their OPPS reimbursement policy in May of 2009 to erroneously include add-on codes in the multiple surgery reduction rule. Tricare is aware of the error and is in the process of correcting the policy and related system edits. The AAD has received the following information from Tricare regarding the incorrect application of the multiple surgery reduction rule to add-on CPT codes:

— see **CODING UPDATE** on page 4

Coding Update

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A change to allow add-on/modifier 51 codes for professional provider reimbursement at 100 percent is expected within the next couple of weeks. A draft of the change has been received and reviewed. Wisconsin Physicians Service has already started to make the necessary update in the claims system.

Once the final change is received and the claims system is updated, all claims with dates of service May 1, 2009, with the add-on codes/modifier 51 exempt will be adjusted.

CIGNA DOCUMENTATION REQUIREMENT UPDATE

CIGNA met with American Academy of Dermatology representatives on the status of the current policy to require documentation with published code pairs requiring the -25 and -59 modifier. As a result of the positive review of dermatology documentation, CIGNA will reduce the number of code pairs that directly affect dermatology from 87 to 62. This new list will go into effect May 17, 2010.

Following is a summary of the CIGNA study findings that were shared with the AAD.

- 41% of all claims audited were missing the appropriate modifier
- 27% of all claims audited were dermatology specific
- CIGNA's Goal is 99% of all claims to be submitted correctly
- 27% of documentation is inadequate for codes billed on claims audited
    - After 3 month review this number dropped to 17%

The recent OIG study noted that 40% of Medicare claim documentation is inadequate which is higher than the CIGNA study findings.

Aetna's new payment policy for mid-level practitioners

Aetna has announced a change in policy regarding payment for services provided by mid-level practitioners. Starting June 1, 2010 Aetna will pay mid-level practitioners at 85 percent of the contracted rates for covered professional services. This policy applies to nurse practitioners (NPs), physician assistants (PAs), registered nurses, among others who qualify as mid-level practitioners, and is consistent with the Centers for Medicare and Medicaid Services (CMS) payment policy.

As of June 1, NPs and PAs billing Aetna directly will need to list their names in the servicing provider field when submitting claims for services rendered by a mid-level practitioner. Aetna also clarified that this new payment policy will not apply to the following states: Alaska, Kansas, Maine and Missouri.

ASSESSING PRACTICE IMPACT

Dermatology practices employing NPs and/or PAs may:

- Have their mid-level practitioners bill Aetna directly as the servicing or rendering provider and receive 85 percent of the physician contracted rate; or
- Follow and meet Medicare's "incident-to" guidelines, allowing the NP or PA to bill under the supervising physician's name, when appropriate, with reimbursement at 100 percent of the physician contracted rate. For more information on incident-to-guidelines, visit the Academy's website at *http://www.aad.org/pm/billing/medicare/_doc/FAQonIncidentToBilling.pdf and http://www.aad.org/pm/education/webinar/PMWebcasts.html*

FOLLOW-ON STEPS

Dermatology practices should consider the appropriate decision based on their particular practice situation.

- Dermatology practices should contact their Aetna provider representative for additional details.
- Double check your state's scope of practice laws and licensing governing the use of NPs and PAs in the practice of medicine and physician supervision. Note that just because your state may require physician supervision doesn't mean that all medical services should be billed under the incident-to guideline. Visit *http://www.aapa.org/advocacy-and-practice-resources/state-government-and-licensing for a breakdown of state laws concerning PAs; and/or http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465* for state scope of practice laws governing NPs.
- Review your Aetna contract to see if any changes will be needed. Ensure there is specific language that states that your NPs and/or PAs are covered for services consistent with your state law and licensing guidelines regarding physician supervision and scope of practice.
- Regarding credentialing of mid level practitioners, unless state law licensing requirements or other Aetna policy dictates otherwise, you do not need to credential employed mid-level practitioners since Aetna contracts hold physicians (groups) accountable for credentialing their employees and subcontractors. However, if the mid-level practitioner is going to be in the role of a primary care provider, Aetna policy requires that they must be appropriately credentialed.
- Aetna's revised Mid-level Practitioners Contracting Policy provides an opportunity for dermatology practices to consider enrolling their NPs and/or PAs. Enrolling in Aetna's network will mean that your NPs and/or PAs will appear in the provider directories, and they will become an in-network health care professional subject to accepting the in-network fee schedule for medical and surgical services.

Aetna is advising that the policy is applicable to participating and nonparticipating providers. Aetna will be following CMS' "incident to" payment policy. In addition to the payment policy change, dermatology practices will have an opportunity to make sure the names of their NPs and PAs appear in Aetna's provider directories. For information on joining Aetna's network, go to *www.aetna.com*. For other questions including the process for submitting practitioner contact information, contact your Aetna network representative.

Billing Medicare Beneficiaries for Covered Services: Potential Assignment Violation

As the decline in Medicare reimbursements continues, dermatologists may want patients to pay additional fees for services, but dermatologists need to avoid violating the rules governing Medicare assignment and limiting fees.

In order to bill a Medicare beneficiary any upfront fees, dermatologists must first address these two rules. The Medicare assignment rule requires participating providers to accept the Medicare allowable fee as full payment for covered services and prohibits the participating provider from balance billing Medicare beneficiaries for any fees other than unmet deductible, co-pay and co-insurance for covered services. The limiting fee rule prohibits nonparticipating providers from charging more than 115% of the Medicare allowable fee.

Participating Dermatologists are cautioned that it is a violation of Medicare Provider participation and assignment agreement to charge an "Annual Fee" and then bill Medicare for office visits. Billing a Medicare beneficiary directly for services deemed as **"covered"** is also considered a violation of the agreement and may lead to substantial monetary penalties and exclusion from Medicare and other Federal health care programs. Non-participating dermatologists may also be subject to penalties and exclusion for overcharging beneficiaries for covered services. This is true whether the provider accepts assignment for a given service or does not, in which case the provider's charge is limited to the "limiting charge."

WHO IS A PARTICIPATING PROVIDER?

A participating provider is one who provides Medicare covered items and services to a Medicare beneficiary. To become a participating provider, the provider agrees to accept the Medicare-approved charges for all covered services upon Medicare provider enrollment application. A participating provider "accepts assignment" for all Medicare-payable services.

Participating dermatologists can charge beneficiaries extra for items and services that are **not covered** by the Medicare program. Chapter 16 of the Medicare Internet Only Manual (IOM) #100-02, can be viewed at *http://www.cms.gov/manuals/Downloads/bp102c16.pdf* for more details of non-covered services.

The OIG states that "Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare." For example, it is a violation of the assignment agreement when a provider presents a bill to a Medicare beneficiary to pay in advance or to pay an "Annual Fee" for "non-covered services" provided and then bill Medicare or the insurance company. It is assumed that some of the services covered under the "Annual Fee" may be covered services and hence reimbursable by Medicare.

Participating dermatologists may charge beneficiaries for any Medicare co-pays, deductibles and coinsurance without violating the terms of their assignment agreements. The OIG has stated that it is not a violation of Medicare law if the fee charged by dermatologists is only for non-covered services.

PRIVATE PAYER ISSUES

When considering an upfront payment from patients, dermatologists must review their contracts with private payers since many contain provisions similar to the Medicare assignment and limiting charge rules. It is imperative to review one's current provider contracts to determine if such a move would:

- breach the current provider payer contracts;
- be possible to structure the proposed practice to fit within the current contracts;
- be in compliance with state rules and regulations.

It is a slippery slope between medical and non-medical services. Therefore, it is prudent for dermatologists to consult with a healthcare attorney before implementing such a policy in their practice.

Timely Filing Requirements for Medicare Fee-For-Service Claims

CMS FILING DEADLINES

Claims before October 1, 2009: Follow the prior timely filing rules of 15 to 23 months

Claims from October 1, 2009 – December 31, 2009: Submit by December 31, 2010

Claims after January 1, 2010 – Submit within one calendar year of the date of service

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. Claims with dates of service before October 1, 2009, must follow the prior timely filing rules of 15 to 23 months depending on the date of service. Section 6404 of the PPACA allows for exceptions, however, proposals for exceptions will be specified in future proposed rulemaking.

2009 PQRI Feedback Reports

Due to the many complaints CMS has received from physicians on the poor PQRI feedback response, CMS advised that they will provide confidential feedback reports on calendar year 2009 PQRI reporting to Individual Eligible Professionals (EPs) at or near the time that the lump sum incentive payments are made in 2010 as well as a report for 2009 E-Prescribing bonus. Prior, the only option for accessing these reports was through a secure CMS website known as the Individuals Authorized Access to CMS Computer Services (IACS).

CMS' alternative process for Individual EPs requesting feedback reports is based on the National Provider Identifier (NPI) beginning in 2009. Individual EPs will be able to call their local Medicare carrier or A/B MAC provider to request a PQRI or E-Prescribing feedback reports using their individual NPI. The feedback is only available under the NPI number and feedback reports available in 2010. The EP needs to call and place a request to their local Medicare contractor for the 2009 feedback report sent to their personal email. CMS's last teleconference call advised the 2009 feedback reports will be available late spring.

Requests for feedback reports based on Tax Identification Numbers (TINs) or by groups will still be required to access their PQRI Feedback Reports via a secure Web Site after first registering in IACS.

CMS: Pub 100-09, Chapter 6, §§30 and 90.

Q&A

Q) Can you bill Medicare for the injection of facial fillers for HIV infected individuals where facial lipodistrophy is a major contributor to their depression?

A) Yes. As of March 23, 2010, the Centers for Medicare & Medicaid Services (CMS) announced its decision to cover facial injections for Medicare beneficiaries who experience symptoms of depression due to the stigmatizing appearance of severely hollowed cheeks resulting from the drug treatment for human immunodeficiency virus (HIV). This decision is effective immediately. You would code this per the following guidelines:

COVERED CPT CODES

11950 Subcutaneous injection or filling material 1cc or less

11951 Subcutaneous injection or filling material 1.1 cc to 5.0cc

11952 Subcutaneous injection of filling material 5.1 cc to 10.0cc

11954 Subcutaneous injection of filling material over 10.00cc

HCPCS CODE

S0196 Injectable poly-l-lactic acid, restorative implant, 1ml, face (deep dermis, subcutaneous layers)

COVERED ICD-9-CM DIAGNOSIS CODES

Both of the following diagnoses must be present to meet medical necessity, as per the criteria above.

042 HIV

272.6 Lipodystrophy

CORRECTION

In DCC of Spring 2010, the following Q&A was printed with incorrect CPT Code 19000. Please accept our apology. The correct Q&A should have read....

Q) How do we code for CANDIDA Antigen injection for warts? Is it intralesional medication 11900 or destruction 17110? There is no code drug code for Candida.

A) 11900, intralesional injection would be the appropriate CPT code to report. Since there is no code for this off label use report the drug as the unspecified drug code, J3490. In box 19 on the CMS 1500 claim name the drug, strength and dosage. If possible add the NDC# usually found on the bottle or box.

2010 – CMS Year for Provider Enrollment Re-validation

The Centers for Medicare & Medicaid Services (CMS) has instructed all its Medicare Administrative Contractors (MACs) to begin the provider enrollment revalidation process for all physicians currently not in Provider Enrollment Chain and Ownership System (PECOS).

The MACs are compiling a list of active physicians not in PECOS. They will create and send a plan to CMS on how they intend to proceed with revalidating those physicians over a 12-month period – either by enrolling them using CMS's Internet-based PECOS application system or through traditional paper applications.

CMS outlined several types of providers they will actively seek to revalidate enrollment as:

- Providers who have not updated their provider enrollment within the last five years;
- Providers located in historically high-risk areas for fraud;
- Providers who don't receive electronic funds transfer (EFT) payments; and
- High-reimbursement providers

The provider enrollment revalidation is consistent with the Federal Regulations found at 42 CFR 424.515 and Pub. 100-08, PIM, Chapter 10, Medicare Provider Enrollment, which states that physicians and suppliers are required to revalidate their enrollment information every five years.

Dermatologists are advised to act promptly upon receiving a revalidation request and to respond within 60 days to update their information – or risk the loss of billing privileges and disruption of Medicare reimbursements. See DCC Winter 2009 page 6 article on "Medicare One-Time Mailing" to learn how to update provider information with your local Medicare Carrier at *http://www.aad.org/members/publications/_doc/DCC_Winter09.pdf*

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PQRI Reporting Update!

The AAD has initiated a new website called the Quality Reporting System (QRS). QRS is where the AAD houses all quality reporting modules. It currently offers two quality reporting modules for member purchase: 2010 PQRI Melanoma Reporting and E-Prescribing. These modules can be purchased in conjunction with CPAT, which fulfills Component 4 of Maintenance of Certification, as well as earns members CME hours.

The 2010 PQRI Melanoma Reporting module allows members to submit information via a qualified electronic registry for the three dermatology-specific measures. CMS will no longer accept claims-based submissions for these measures. All three dermatology measures, which detail best practices in care for melanoma patients, must be reported in order to be eligible for the incentive payment. Since its activation (March 31st), staff has fielded a number of questions about the product and approximately 100 participants have signed on thus far.

Additional facts are listed below:

1. The modules will be available for purchase until approximately mid-December.
2. Participants have until January 31, 2011 to submit all measures.
3. Each provider has to purchase modules individually – there is no option for group purchases.
4. The system currently does not allow for Physician Assistants (PAs) and Nurse Practitioners (NPs) to submit measures; however, the system will be opening access to those providers in approximately one month.

For more information (including helpful video tutorials) and to purchase the modules – please go to www.aad.org/QRS. Any questions about QRS can be directed to Alison Shippy in the Science and Quality Department (ashippy@aad.org).

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