Future of Dermatology and Strategic Planning for Dermatologists

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Disclosures and Conflicts

Novascan - Consultant, investor
Myriad Genetics - Consultant
Where We Have Been
Where We Are Going
Major Waves

- Affordable Care Act.
- ACOs and APMs.
- Narrow networks, High deductibles.
- Demographics: Aging of baby Boomers.
- Big Data; Data Derm, Medicare data, Mod Med.
- --Benchmarks, bundled payments, quality metrics.
Major Waves

• Declining revenue, increasing regulation.
• Some pay cuts disguised as quality (United lab benefit program)
• NPs and PAS.
• Corporate Medicine.
• -25 cuts.
Specific Threats to Dermatology

- Medicare Advantage profiling and excluding.
- Loss of global periods (embedded follow up visits). (Aks, B-9 destruction, shaves, closures) Derm loses one billion ($100,000 per Dermatologist) from Medicare alone.
- ACA; Pressure to join groups, Medicaid expansion, high deductibles, ACOs, IPAB.
- MACRA/MIPS = 90% of current Medicare.
- Independent practice Derm NPS/PAs.
- -25 reductions Anthem, designated labs United.
The Four “Legs” of Health Care
Uncomfortable Nonnegotiable

- Physicians are politically weakest leg.
- 72 millions boomers retiring in next 18 years, 10,000 per day.
- No money “put aside”.
- Medicare projected to be broke in 2029.
- Can’t confront voters directly.
72 Million Baby Boomers
Charles Gaba / ACASignups.net estimates of total U.S. healthcare coverage as of March 2016
Based on composite data from the CBO, CDC, HHS, CMS, BLS, Census Bureau
Kaiser Family Foundation, Mark Farrah & Associates, etc.

1. Employer - Lg. Group (private) 100.0 million (30.9%)
2. Employer - Sm. Group (private) 17.0 million (5.3%)
3. Employer (Fed/Stata/Local Gov't) 22.0 million (6.8%)
4. Employer (Military - TriCare/VA) 14.0 million (4.3%)
5. Medicare - Traditional (Seniors) 29.4 million (9.1%)
6. Medicare Advantage 17.2 million (5.3%)
7. Medicare (Under 65) 8.9 million (2.8%)
8. Medicaid (Traditional - Adults) 11.0 million (3.4%)
9. Medicaid (Traditional - Children) 29.9 million (9.3%)
10. Pre-ACA CHIP (Children) 8.1 million (2.5%)
11. Medicaid/CHIP (ACA Expansion) 11.0 million (3.4%)
12. Medicaid/CHIP (Woodworkers) 3.0 million (0.9%)
13. Exchange Based (Subsidized) 9.1 million (2.8%)
14. Basic Health Program 0.5 million (0.2%)
15. Exchange-Based (Unsubsidized) 1.9 million (0.6%)
16. OFF-Exchange (ACA Compliant) 6.0 million (1.9%)
17. OFF-Exch. (GF/Transitional) 1.2 million (0.4%)
18. Other (IHS, Student, CH+, etc.) 4.0 million (1.2%)

SUBTOTAL: 294.2 MILLION (91.0%)

19. Uninsured - Medicaid Eligible 5.0 million (1.5%)
20. Uninsured - CHIP Eligible 3.0 million (0.9%)
21. Uninsured - Medicaid Gap 2.8 million (0.9%)
22. Uninsured - Undoc. Immigrants 4.7 million (1.5%)
23. Eligible for Tax Credits 6.5 million (2.0%)
24. Ineligible for Tax Credits 7.0 million (2.2%)

SUBTOTAL: 29 MILLION (9.0%)

TOTAL U.S. POPULATION: 323.2 MILLION
Medicaid = Hospital Coverage

- Pays office physician less than practice expense.
- Useful for ER/Hosp? Rural Hospitals going bust.
- Physician low participation problem for politicians, they cannot/will not increase Medicaid rates.
- Be aware “National” medical license. May have hidden agenda with mandated Medicaid participation.
- Be aware “single payer” or “Medicare for all” will be at Medicaid rates.
Affordable Care Act Regulations Being Dismantled
Lifetime expenditure is $316,600, females ($361,200) males ($268,700).

• 60 percent—$188,658—of the total lifetime cost of survivors is spent after age 65
• > age 85, 1/3 of lifetime expenditures still to come.
• The older you get the more health care you consume. Unsustainable.
Government Overpromised

• Life expectancy 1965; 70.20 years,
• 2012; 78.7 years,
• Projected 2030; 81.18 years.
• Expense/Disease intensifies as we age.
• You survive to die of something else.
Beware Smiling Politicians

"We are ushering in the end of the fee-for-service care system in Massachusetts."

Massachusetts Gov. Deval Patrick joins legislators, advocates and stakeholders to sign a law launching the next phase of health system reform in the state. With the new legislation, Patrick says Massachusetts has "cracked the code" on controlling health care costs, but doctors and hospitals still have reservations about keeping spending at or below the growth of the state's economy.
How Do you Ration health Care? (without rationing)

• You make services hard to get, deny care.
• ---Cut the weakest leg, the doctors!
• You enact price controls, lines get long, people get well (or pay out of pocket) or die of something else while waiting.
• You divert to midlevels = (only cost 85%).
  ---(won’t save money, order more tests)
• You require prior authorizations (make prescribing painful)
-25 Payment Reduction

• Anthem claims overlapping work with E and M.
• Planned to reduce payment for E/M by 50% when appended with -25.
• AAD and AMA pointed out this overlap has already been factored in by the RUC, actively opposing.
• Anthem reduced cut to 25%. Still plans on implementing.
United Health Care Lab Program

• “our pathology utilization has increased 2 or 3 x per year for 7 years”
• Derm path mostly exempted.
• Mohs exempted.
• Must fill out multiple forms.
• Controlling cost of path, real issue is number of skin biopsies.
What United Lab Program is Really About

• Number of skin biopsies in Medicare data alone, has grown from 1 million to 3.3 million in past 20 years. (1/7 of population)
• “unsustainable expense”
• Number of skin malignancies in Medicare a little over 1.5 million.
• They can control path, can’t control biopsies, yet.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>% Increase</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>1st Skin Biopsy</td>
<td>200%</td>
<td>(3.3 million)</td>
</tr>
<tr>
<td>88305</td>
<td>96%</td>
<td>(17,647,442)</td>
</tr>
<tr>
<td>Malig Destructs</td>
<td>65%</td>
<td>(866,011)</td>
</tr>
<tr>
<td>Malig Excisions</td>
<td>18%</td>
<td>(764,817)</td>
</tr>
<tr>
<td>Mohs</td>
<td>410%</td>
<td>(675,245)</td>
</tr>
<tr>
<td>Ak’s 15 or &gt;</td>
<td>200%</td>
<td>(839,605)</td>
</tr>
</tbody>
</table>
Well, What about the skin Cancer Epidemic?

- Skin cancer increasing at average of 2% a year in Medicare population, compounded for 20 years = 49% increase.
- Assume other procedures follow this trend.
- This increase in procedures cannot be wholly (or even half) explained by the skin cancer epidemic.
Biopsy Use in Skin Cancer Diagnosis: Comparing Dermatology Physicians and Advanced Practice Professionals

• When billing independently take twice as many skin biopsies to reach a malignant diagnosis.

• Midlevels bill independently for 13% of all Medicare skin biopsies.

• The “just biopsy it” model unsustainable.

• Expect # biopsies/provider comparisons.
Marked increase in # skin biopsies.

Sharp rise in number of unsupervised physician assistants.

15% of all skin biopsies by NPs and PAs.

3 PAs and 1 NPs freezing Alzheimer patients in 72 different nursing homes.

This is unsustainable.
Quality Standards and Benchmarks

• OK, I’m an efficient, well trained dermatologist, I’m ready to be compared to anyone!

• No your not.
Insurer Quality Standards are a Travesty

- No quality measures exist for use by insurers for derm.
- Cigna one star based on rest of large group reporting, 2nd star based on average cost (no subspecialist categories). Not based on quality or evidence based medicine.
- Rest are based on average cost. Optum 360.
- Dynamic data collection, real time.
- We need quality measures and benchmarks.
• Episodic and chronic measures are attributed to specialty care physicians using the percentage of professional costs or in the event of a tie, the highest number of visits.
Benchmarks; This Won’t Work
Expect Benchmarks

- How many skin biopsies to get to malignant diagnosis?
  Must allow for different subspecialties of Derm.
- How many special stains on path?
- How many Mohs on trunk/extremities?
- How often return for AK destruction?
- How many shave excisions?
- How many b-9 destructions?
Mean Stages/Case for entire Medicare Database in 2012

Histogram

Descriptive Statistics

<table>
<thead>
<tr>
<th>Statistic</th>
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<tr>
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<tr>
<td>Median</td>
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<td>Standard Deviation</td>
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<tr>
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<td>Maximum</td>
<td>4.471483</td>
</tr>
<tr>
<td>Sum</td>
<td>3651.615</td>
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<tr>
<td>Count</td>
<td>2133</td>
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</table>
Individual Surgeon Data Report

Improving Wisely Quality Collaborative
Benchmarking Performance Among Peers Using an ACMS-Endorsed Metric

Data for Dr. Coldiron (NPI: 144297847):
The graph represents the distribution of physicians performing Mohs surgery in the U.S.,

The average number of stages per case for a surgeon in the U.S. = 1.7 stages per case
Your avg stages per case = 1.6 stages per case

How your performance was calculated
The American College of Mohs Surgery collaborated with the Improving Wisely project to develop and report data around one unique quality metric which allows for peer-comparison, and which we believe represents high quality, high value care. Your performance was calculated using 100% Medicare Part B claims (January 2014-December 2014) and compared to that of 2,262 other surgeons billing for Mohs surgery to Medicare. The metric reported is stages per case for head and neck Mohs surgery, and it was calculated using the following:

CPT Code 17311 - Mohs micrographic technique performed on the head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.
CPT Code 17312 - Each additional stage after the first stage, up to 5 tissue blocks.

Stages per case = (17311 + 17312)/17311

*The analysis includes surgeons who performed more than 10 procedures per year.
More Money/Authority for Audits in ACA; Expect more Audits

- OIG/ZPIC/RAC/CERT audits more frequent and annoying.
- OIG > 24 hours services in a day. *My cases that day weren’t typical, consider not scheduling more than 5 Medicare fee for service Mohs/repairs/day.*
- ZPIC- fraud and abuse (high utilization, whistle blower, act quickly, recoupment or refer to OIG)
- RAC- identify overpayments, (88305 with Mohs)
- CERT- comprehensive error rate testing.
NEW products from the Medicare Learning Network® (MLN)
- “Annual Wellness Visit,” Podcast, ICN 908726, Downloadable only.

MLN Matters® Number: SE1318
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Guidance To Reduce Mohs Surgery Reimbursement Issues

Provider Types Affected
This MLN Matters® Special Edition Article is intended for physicians and hospitals submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for providing Mohs Micrographic Surgical (MMS) services to Medicare beneficiaries.

What You Need to Know
Medicare will only reimburse for MMS services when the Mohs surgeon acts as both surgeon and pathologist. You may not bill Medicare for these procedures if preparation or interpretation of pathology slides is performed by a physician other than the Mohs surgeon.

Background
Mohs Micrographic Surgery (MMS) is a precise, tissue-sparing, microscopically controlled surgical technique used to treat selected skin cancers. It is an approach that aims to achieve the highest possible cure rates, and minimize wound size and consequent distortions at critical sites such as the eyes, ears, nose, and lips.

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Coding and Documentation Guidance to Help Prevent Reimbursement Problems

The majority of skin cancers can be managed by simple excision or destruction techniques. The medical record of a patient undergoing MMS should clearly show that this procedure was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important). Medicare will consider reimbursement for MMS for accepted diagnoses and indications, which you must document in the patient's medical record as being appropriate for MMS and that MMS is the most appropriate choice for the treatment of a particular lesion.
You must describe the histology of the specimens taken in the first stage. That description should include depth of invasion, pathological pattern, cell morphology, and, if present, perineural invasion or presence of scar tissue. For subsequent stages, you may note that the pattern and morphology of the tumor (if still seen) is as described for the first stage; or, if differences are found, note the changes. There is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.
July 14, 2015

RE: Post-payment Review Results and Provider Education
PTAN: < >
NPI: < >
Tax ID: < >

Dear Dr.

You are receiving this packet as a result of a Medicare Program Integrity Post-Payment Review conducted by AdvanceMed Corporation. This letter and the attachments hereto serve to provide you with detailed information on the results of our review as well as supply you and your staff with additional education regarding our findings. In accordance with Section 1893 of the Social Security Act [42 U.S.C. 1395ddd] and Title II § 202 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Centers for Medicare & Medicaid Services (CMS) is authorized to contract with entities to fulfill program integrity functions for the Medicare program. These entities are called Zone Program Integrity Contractors (ZPIC). AdvanceMed is a ZPIC for Medicare Part B services in Alabama. As a ZPIC, AdvanceMed performs program integrity activities aimed to reduce fraud, waste, and abuse in the Medicare program.

On July 15, 2014, AdvanceMed opened an investigation based on data analysis that showed you as having an unusually high total paid amount for the number of beneficiaries you provided services for, indicating that you were paid more per beneficiary than your peers.

AdvanceMed, through its investigative process, determined that a medical review of a Non-Statistical sample of the provider’s submitted claims was necessary to affirm or deny the allegations.

On January 5, 2015, AdvanceMed faxed a medical records request to Gayla Carter at (205) 977-9976. AdvanceMed received and reviewed 23 claims / 109 CPT line items. Eighteen of 23 or 78% of the reviewed CPT line items failed to meet existing Medicare coverage policies and were denied. The medical review identified the following general findings:

- Documentation did not support the MOHs surgery was actually performed. The documentation on 18 claims for MOHs surgery did not include the microscopic examination of the specimen(s), as required.
- Documentation did not support CPT 99202/99212 were reasonable and necessary. Modifier 25 was appended to indicate that this was a significant, separately identifiable and unrelated evaluation and management service performed by the same physician on the same day of the procedure or other service during a global period, but was not supported by the documentation. All 99202/99212 services were denied as not reasonable and necessary.

“*This correspondence contains data and/or information that are protected under the Privacy Act and/or the Health Insurance Portability and Accountability Act of 1996. The improper use or disclosure of this confidential and protected information may result in criminal and/or civil sanctions.*” OMB Paperwork Reduction Act collection number is 0938-0969.
Need to add Mohs Documentation, Be Proactive

- Only Noridian and Cahaba currently auditing for this but all may;
- Need: Histopath description, even if benign, additional diagnoses if using -25 for E@M on same day as Mohs, unless you are also billing for a flap or a graft with -57. (90 day global).
- ? more than 5 FFF Medicare Mohs/day
Screw This! I’m Selling Out.

- Venture capital buying, threatening.
- Expect 4-7 x EBITA, you will pay this back over 3-5 years in lower income. No free lunch.
- Lose control, will add other “docs” extenders.
- Capital gain “kicker”? worth what/ down the road.
- Real money is when aggregate is resold x 13-15 x EBITA.
- Unsustainable. Little real cost savings. Unless they have better contracts.
What's a Global Period?

• Follow up visits built into the original code, almost all Derm procedures except skin biopsy and Mohs have built in follow up payments.
• Vary from one follow up visit (AK destruction) to Five (graft nose).
• 1 billion dollars to Derm in Medicare alone for follow ups.
• 1 billion/10,000 Derms = $100,000 per derm.
Example

- 17000 (destruction first AK)
- Work RVU 0.61
- Bundled Visit 0.48
- New work RVU = 0.13
- Reimbursement for Aks get cut over ½.
CPT Code Du Jour

• 99204
• Follow up visit. No pay. CMS is monitoring 9 states
  • Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island
• If you work in one of these states use 99204 any time you see or call a patient and don’t bill a EM code.
• If they eliminate globals will need legislative fix (like before). Better donate to skin PAC.
What's coming Up?

• Shave skin biopsies will be cut.
• Aks and B-9 destructions may get cut 65% from loss of global period by 2019. Reconstructive surgery safe until 2018, then globals may be cut, (5 level 3 f/u visits ($400) in a nose graft!).
• Esthetics /Cosmetics safe but fierce competition. Safe harbor until next recession.
Go to Work for the Hospital or Large Group?

• Good initial pay, benefits, maybe bonus!
• Earning will be capped “can’t pay you more than the surgeons!”
• Loss of control, (staff, hours, vacation, call)
• Pay by work RVUs (no savings from practice expense)
• Loss of globals will translate in to lost RVUs.
• Fierce noncompete from all outlets.
Predications

- Restrictions by privates on who can read dermpath.
- Benchmarks on numbers of layers for Mohs, number of 88331s, % flap repairs, skin biopsies.
- Derm “biopsy clinics” restricted.
- TC path labs restricted.
Boiled Down

- Future income will be less. May no longer be a shortage of Dermatologists. Don’t promise big salaries, unless hinged to income generation.
- University, hospital or multispecialty groups will suffer, much of your income is from clinical work.
- Academics need to look for sources other than clinical income.
- Don’t build palaces. Time to hunker down.
- Sell the Pig to venture capital! They are clueless.
What can You Do Now?

Compare:

- Mohs first/second layers ratios. Should be 1.4-1.7, must be less than 2.4.
- Skin biopsy/malignancy ratio, including midlevels, should be 30-50%, much lower for pediatric derm.
- Calculate what to charge for bundled treatment of skin cancer, Mohs/repair/follow-up. ($1400-1800)
- Check number of complex vs layered closures
- Check number of special stains compared to peers
- Bill 99024!