POLICY & PRACTICE

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ASMS Opposes Subcertification

The American Society for Mohs Surgery is coming out in opposition to the American Board of Dermatology's proposal for a subcertification in procedural dermatology. Such a certification would be redundant, said ASMS President Stephen Spencer, in a statement. The proposal, if passed, "will divide the house of dermatology between medical and surgical, lead to economic credentialing, and may lead to increased litigation if a new standard of care is perceived," said Dr. Spencer. The American Board of Medical Specialties Committee on Certification, Subcertification and Recertification was due to meet in early August.

Texas Gets Tough on Tanning

Gov. Rick Perry (R) has signed Texas House Bill 1310, which, beginning in January 2010, prohibits anyone under the age of 16½ from using a tanning bed. It also requires in-person parental consent for anyone between that age and 18. Tanning salons are also required to keep records of visits for 3 years after a patron's last session. The American Academy of Dermatology said that Texas is the first state to prohibit use of tanning beds for children under 16½. "Texas's leadership on this issue will serve as a model for other states to improve their laws and regulations," Dr. Evan Farmer, AAD vice president, said in a statement.

Florida Boosts ABD Certification

When Florida Gov. Charlie Crist (R) signed Senate Bill 720 in mid-June, the Florida Society of Dermatology and Dermatologic Surgery celebrated a "victory" for dermatology and patients. In an online letter, FSDDS President Albert J. Nemeth advised members to read "between the lines" of the law's wording: "A physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the Board of Medicine." That means, wrote Dr. Nemeth, that it will be much harder for dermatologists certified through the American Association of Plastic Surgeons or the American Board of Plastic Surgery to stay credentialed in Florida unless they also pursue certification through the American Board of Dermatology.

Clinics Expand Into Dermatology

A wholly owned subsidiary of Walgreens is expanding into a few dermatology services. Take Care Clinics will now offer wart removal by cryotherapy, skin tag removal, closure of minor cuts with Dermabond, treatment of skin irritations, and expanded skin evaluation and treatment for skin infections, injuries, and rashes. The clinics are open 7 days a week and have evening hours. According to Walgreens, there are 345 Take Care Clinics in stores in 19 states, and they're staffed by nurse practitioners and physician assistants.

Generic Biologics Get a Boost

Creating a process at the Food and Drug Administration for approving generic versions of biologic drugs, called follow-on biologics (FOBs), could bring down the cost of biologics, the Federal Trade Commission said in a report, but the 12- to 14-year exclusivity period sought by biologics manufacturers is too long. FOBs wouldn't tread deep into innovative products' turf—those drugs would retain 70%-90% of their market shares and continue making substantial profits—according to the FTC. Rep. Henry A. Waxman (D-Calif.), who has introduced legislation to create a regulatory pathway for FOBs, praised the report, but the Biotechnology Industry Organization said it was based on a "lack of true understanding of the necessary conditions to drive future biomedical breakthroughs."

Vermont Bans Most Pharma Gifts

Vermont Gov. Jim Douglas (R) has signed into law a bill that prohibits manufacturers of drugs, medical devices, and biologics from providing free gifts, including meals and travel, to physicians and other health care providers. The toughest of its kind in the nation, the legislation also requires disclosure of any allowed gifts or payments, regardless of their value. Under the stronger law, manufacturers can give physicians only gifts such as samples intended for patients, "reasonable quantities" of medical device evaluation or demonstration units, and copies of peer-reviewed articles.

FTC Wants 'Pay-for-Delay' Outlawed

A new law to eliminate deals in which pharmaceutical companies agree with their competitors to keep low-cost generic drugs off the market could save consumers and the federal government $3.5 billion a year over the next decade, according to Federal Trade Commission Chairman Jon Leibowitz. In a speech, Mr. Leibowitz said that stopping these "pay-for-delay" deals is one of the FTC's top priorities, although a series of recent court rulings has allowed some of the arrangements to continue. For instance, the U.S. Supreme Court recently declined to hear a case brought by consumers and health plans challenging a $398 million payment by drug maker Bayer AG to Barr Laboratories Inc. to settle the companies' patent dispute over a generic version of the antibiotic Cipro (ciprofloxacin).

—Alicia Ault

MANAGING YOUR DERMATOLOGY PRACTICE

Ask for a Raise

If you haven't taken a close look at your managed care plans recently, you may be shocked to find that you have been staying with a doddering old plan whose fee schedule is terrible, and whose few patients are generating negligible remuneration for your practice—when long ago you could have replaced it with a young, aggressive, well-paying organization.

This is the sort of disagreeable task most physicians plan to do in their "free time" (which, of course, is never). But the effort can be well worth it.

BY JOSEPH S. EASTERN, M.D.

It is a pretty safe bet that third-party payers aren't going to take it upon themselves to pay you more. You have to ask for a raise.

Here's how to do it: First, ask your employees to assemble data starting with lists of the last 50 patients affiliated with each third-party contract. Your computer should be able to assemble these. For each patient, compile diagnoses, procedure codes billed, amount billed and paid for each code, and any problems encountered (especially payment delays and requests for records). Ask for any correspondence on file with claims departments and medical directors over the last year.

Next, send out a questionnaire to each provider relations department. Indicate that you are updating your managed care data. Include a list of your 25 most commonly used CPT codes, and ask for the plan's maximum allowable reimbursement for each.

Then ask some basic questions. Here are the five we ask:

► Does your organization recognize the "-25" modifier?

► If a diagnostic or surgical procedure and an evaluation and management encounter are performed during the same patient visit, does your organization reimburse them as separate services?

► If multiple diagnostic or surgical procedures are performed on the same day, how does your organization reimburse such procedures?

► What are your official criteria for coding consults versus office visits?

► What is your average and maximum time for processing a clean claim?

Have a staffer follow each letter with a telephone call in 10 days to make sure the letter was received and will be answered promptly.

Once the data have been assembled, schedule a meeting with your office manager and your insurance specialist. At the meeting, armed with the answers received from each payer and the data collected, analyze each plan in detail.

How many patients enrolled in the plan are currently active in your office? Is that number increasing or decreasing? How well, compared with other plans, Medicare, and your regular fees, does each one compensate you? How promptly are you paid? What problems have you had with referral and claim forms? Are you permitted to bill patients for noncovered charges?

Now, get more specific. Precisely what is not covered? Which procedures are paid particularly well and which particularly poorly (or not at all), despite being ostensibly "covered"? Are there any weird rules for certain surgical or diagnostic procedures? Do you get an inordinate number of requests for "further information"? Are you asked for the same information repeatedly? Are there problems with "-25," "-78," or other modifiers?

Take a look at the numbers. What fraction of accounts receivable is due to each plan at any particular moment? Is that number increasing? Is that because the number of patients in the plan is increasing, or is the plan losing momentum in bill paying? (The latter is a red flag.)

Also, look at mechanics. How easy is it for patients in each plan to get a referral to your office? Do primary care practitioners dole out referrals as if they were diamonds? (Some plans still give PCPs financial incentives not to refer. Review your contracts.) On those all-too-common occasions when patients show up for an appointment without a valid referral, how easy does the plan make it to get them one quickly?

Finally, talk to your staff. Their subjective impressions are just as important as any hard data. They'll separate the "good" plans from the "bad" immediately, but ask some specific questions, too. Are staff constantly cutting through red tape to get patients seen? Are claim forms confusing or hard to file? How hard is it to reach provider relations—and are they helpful and courteous? Are provider relations representatives constantly calling with inappropriate questions?

Now you have your own up-to-the-minute managed care database. Use it immediately to determine which plans to keep and which to cut loose. Repeat this exercise regularly.

And there's one other important use for the database: Use it to renegotiate fee schedules. Any plan whose fees are below your average remuneration should receive a letter informing them of this. However, tell them that you will be pleased to give them the opportunity to remain associated with your practice if their reimbursements are increased.

They may not give the entire increase you want, but you'll usually get something. If not, reconsider your decision to keep that plan aboard. ■

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