POLICY & PRACTICE

No Such Thing as a Safe Tan

Three papers published in the October issue of Pigment Cell and Melanoma Research contend that there's no evidence supporting the safety of tanning—especially indoor tanning—and they call on the tanning bed industry to cease promoting its services. Dr. David Fisher, president of the Society of Melanoma Research, and colleagues from Massachusetts General Hospital's dermatology department write that while genetic and other factors play a role in skin cancer risk, "the role of UV is incontrovertible, and efforts to confuse the public, particularly for purposes of economic gain by the indoor tanning industry, should be vigorously combated for the public health." Dr. Marianne Berwick of the University of New Mexico, Albuquerque, writes, "Epidemiologic data—incomplete and unsatisfactory—suggests that tanning beds are not safer than solar ultraviolet radiation and that they may have independent effects from solar exposure that increase risk for melanoma." Finally, Dr. Dorothy Bennett of the University of London argues that recreational exposure to ultraviolet light should be discouraged because UV is a known mutagen.

Industry Groups Protest IVIG Cuts

The Biotechnology Industry Organization, the American Society of Clinical Oncology, the Association of Community Cancer Centers, and the Alliance for Plasma Therapies are urging the Centers for Medicare and Medicaid Services to preserve the preadministration fee currently paid for administering intravenous immune globulin (IVIG) therapy in hospital outpatient settings. The CMS proposed to eliminate the payment as part of its hospital outpatient prospective payment system rule for next year. The preadministration payment began in 2006 at a time when IVIG supplies were tight, driving up the price. The CMS says it's not clear that supply is still an issue, but manufacturers and patient organizations say there are still difficulties. "BIO does not believe that there is stability in the IVIG marketplace when over 40% of the providers cannot purchase IVIG at or below the Medicare payment rate," said the group in its comments. The CMS also said that it wants to cut the add-on fee because IVIG use has gone up markedly. BIO argued that increased use shows that the preadministration payment has helped providers acquire and administer the drug.

CMS Alters Overpayment Policy

CMS officials are changing the procedures for recovering certain overpayments made to physicians. The CMS will no longer seek payment from a physician for an overpayment while the physician is seeking a reconsideration of the overpayment determination by a qualified independent contractor. Under the new policy, which was mandated by the 2003 Medicare Modernization Act, the CMS can only seek to recoup the payment after a decision has been made on the reconsideration. The changes, which went into effect Sept. 29, will apply to all Part A and Part B claims for which a demand letter has been issued. However, a number of claims have been excluded, including Part A cost reports, hospice caps calculations, provider initiated adjustments, home health agency requests for anticipated payment, accelerated/advanced payments, and certain other claims adjustments. The changes do not affect the appeal process or the normal debt collection and referral process, according to the CMS.

HHS Privacy Efforts Lacking

The Health and Human Services department has taken some steps to safeguard patient privacy, but efforts in several areas are still lacking, according to a report from the Government Accountability Office. The report notes that although the HHS has made progress in developing a confidentiality, security, and privacy framework for health records, it has looked at some areas only in a narrow view. For example, the agency's efforts at harmonizing certification and standards mostly address technical issues such as data encryption and password protections, while the recommendations submitted by the HHS's advisory committees are primarily aimed at policy and legal issues. In response, the report noted that the "HHS agreed that more work remains to be done in the department's efforts to protect the privacy of electronic personal health information and stated that it is actively pursuing a two-phased process for assessing and prioritizing privacy-related initiatives intended to build public trust and confidence in health IT, particularly in electronic health information exchange."

Immigrants Must Get HPV Vaccine

Young women seeking to immigrate to the United States currently are required to be vaccinated against the human papillomavirus, under an amendment to the Immigration and Nationality Act. Under the 1996 amendment, individuals seeking immigrant visas must provide proof of vaccination for all vaccines recommended by the U.S. Advisory Committee for Immunization Practices. This list, which is updated periodically, now includes HPV vaccination for females aged 11-12 years, with catch-up vaccination among those aged 13-26 years. The addition of the HPV vaccine to the list of required vaccines for immigrants was automatic and required by statute, according to Centers for Disease Control and Prevention spokesman Curtis Allen, and was not part of ACIP deliberations when the committee originally recommended use of the HPV vaccine. According to a spokeswoman for Merck & Co., the HPV vaccine Gardasil costs approximately $290-$375 for the three-dose series. The company was not aware of the immigration policy and did not lobby for that provision, she added.

—Alicia Ault

MANAGING YOUR DERMATOLOGY PRACTICE

Staying on Schedule

Last month, I discussed the complaint patients make most often: waiting too long to see the doctor. I suggested ways to help you stay on time, but ultimately, your success in staying on schedule depends in large part on your schedule.

No practice can run on schedule every day. There are simply too many uncontrollable variables inherent in the practice of medicine. And no single scheduling system is perfect for every practice.

BY JOSEPH S. EASTERN, M.D.

The most traditional and probably the most popular scheduling system is continuous scheduling. Patients are booked at regular intervals throughout the hour; for example, the first at 9 a.m., the next at 9:15, the next at 9:30, and so on. (In the interests of clarity and simplicity, I am assuming a rate of one patient per 15 minutes. If you schedule two or even three per 15 minutes, adjust the numbers accordingly.)

Continuous scheduling is popular with patients, but it is far less than ideal for most dermatologists running high-volume practices. If the 9-a.m. patient arrives late, your entire half-day is delayed before you even start. Similarly, a single visit that takes longer than anticipated, or one unplanned patient who needs urgent care, will throw off the entire schedule.

Even without late patients or work-ins, continuous scheduling can be inefficient in high-volume offices because the workload tends to pile up toward the end of each hour as new patients arrive and you struggle to keep up.

For many offices, a better system is wave scheduling. Instead of one patient per 15 minutes, you would schedule two or three per half-hour, or three on the hour, two at 20 minutes past, and one at 40 minutes past, so that patients arrive in waves, rather than continuously. In that way, variations in time needed per patient, as well as problems created by the inevitable disruptions, will average out over each hour during the day.

Also, those end-of-hour pileups are minimized because most patients come in early in each hour.

A third, relatively new scheduling option, called open-access scheduling, is gradually gaining in popularity. More about that next month.

No appointment system, though, no matter how efficient, will eliminate the problems created by common disruptions—no-shows, tardy patients, tardy doctors, and "work-ins"—and each must be addressed individually.

Dealing with no-shows is a column in itself—particularly in dermatology, where the no-show rate is much higher than average. That column ran in the December 2004 issue, and you can find it in the archives at www.skinandallergynews.com.

To briefly summarize, you can eliminate one of the major reasons patients miss appointments—simple forgetfulness—by calling them the day before. Reasonably priced phone software is available from a variety of vendors to automate this process. You could also hire a teenager to do it after school each day.

Document each missed appointment in the patient's chart; it's important clinical and medicolegal information. A second missed appointment should prompt a warning, either verbal or written, that measures will be taken if it happens again. Such measures might include a charge before future appointments will be accepted, a nonrefundable advance deposit (for surgical procedures), or outright dismissal from the practice. Habitual no-shows should be dismissed. You cannot afford them.

Late-arriving patients need to be politely advised by a staffer that the efficient flow of the office depends on their punctuality. Anyone arriving more than half an hour late should be rescheduled. Treat habitually tardy patients the same way you deal with no-shows.

Of course, patients aren't the only culprits when schedules run late; all too often, it's the physician's fault.

Most patients understand unavoidable delays, but they resent being kept waiting without an explanation. You should never take shortcuts with a patient's care to see the next patient on time, but when it becomes clear that unforeseen issues will cause delays, make sure your staff explains that to patients who will be affected by it. Offer to reschedule them if the delay will be significant.

Unscheduled visits should be permitted only in situations that are truly urgent. As I mentioned last month, work-ins should be inserted as late in the schedule as possible to minimize inconvenience to patients with appointments. And once again, when a work-in does put you behind schedule, make sure the patients who are affected receive a prompt explanation. ■

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