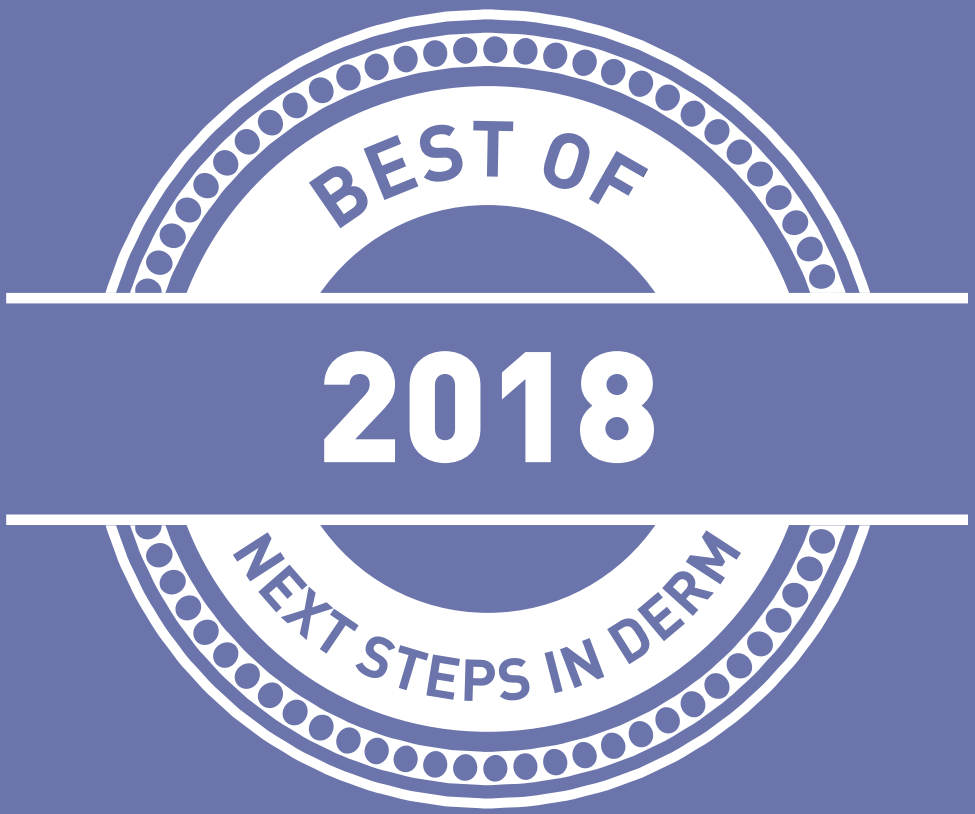
NEXTSTEPS IN DERM

Dermatology Career Resources
for Young Dermatologists and Residents



A review of the most popular articles from Next Steps In Derm - a top career resource for Residents and Young Dermatologists.

For more great articles visit **NextStepsInDerm.com**

JDD JOURNAL OF DRUGS IN DERMATOLOGY

A product of sanovaworks

Sponsored by Pfizer

Table of Contents:

Understanding Physician Compensation in Private or Multi-Specialty Practices

BY AHMAD SHATIL AMIN, MD, FAAD

You may have received advertisements and flyers in the mail highlighting attractive starting or base salaries. This is the way many practices lure young graduates. A high base salary is great, but often these base salaries are only guaranteed for one to two years. After that point, you are likely to be compensated on some form of a production model that takes into account your work output or how much revenue your services bring to the employer. Keep in mind that a typical general dermatologist who works four to five days a week and sees an average of 30 patients per day will generate for their employer approximately between $900,000 to $1,200,000 yearly on average. This is not the money you take home, but the money that your employer is making directly from your professional services. And this is the reason why many dermatology practices and multi-specialty practices are eagerly looking to hire dermatologists.

Comparing compensation models

It is important that in addition to the base salary, you look carefully into the specifics of the productivity-based compensation model that will likely take effect once your guaranteed base salary expires. If you are a busy dermatologist, your total productivity-based compensation will likely far exceed your base salary. You may agree to work at a practice that offers a very attractive base salary only to find out later that the production-based compensation is not as competitive. Productivity-based compensation is based on either net collections (the total amount of money you bring in for the practice — payments made by patients and insurers) or total number of work RVU (a metric of work output).

In the collections model, you are paid a certain percentage of the total money that you generate for the practice. The common range can be anywhere between 30-50 percent — obviously the higher

percentage the better for you. For example, if you negotiate to keep 40 percent of net collections, and if you generated $900,000 in collections, your salary would be $360,000. A downside of this model is that the payor mix of your patient population (the types of insurance your patients have) will affect your net collections and thus your net pay.

In the work RVU model, you are paid a set amount of dollars per work RVU that you generate. A little explanation of work RVUs (wRVU): Each procedure or activity that a physician performs is associated with a wRVU value. This value is fixed by national committees and takes into account the amount of time, skill and effort required for each activity. For example, the wRVU value of an established patient level 3 visit is 0.97. A new patient level 3 visit is 1.42 rRVUs. A biopsy is 0.81 wRVUs. In the wRVU compensation model, the physician compensation is calculated by multiplying the total wRVUs performed by a variable called the conversion factor (CF). The CF is set by your employer and may be negotiated. The CF may be anywhere between $47-60 dollars per wRVU (sometimes even higher) — of course, the higher the better. For example, if your conversion factor (CF) is $52 per wRVU, and if you produce a total of 7500 wRVUs in a year, your total salary will be $390,000. As compared to the collections model, the benefit of the wRVU compensation model is that you consistently get paid the same amount for each service regardless of the patient's insurance type.

There are several databases that are available such as the MGMA physician survey that can help you understand the median compensation of dermatologists by geographic region, the median total number of wRVUs generated, and the median value of the conversion factor. These values can help you determine whether the offers you receive are competitive and can help provide data to help in your negotiations.

I Wish I Had Known: Residency Study Advice

BY NEXT STEPS IN DERM TEAM

Dermatology residency is a marathon, not a sprint, you have three years to learn the material and though it is quite a large volume, it is do-able.

As a first year dermatology resident, you will be completely overwhelmed with the pure volume of material you need to know. First year, read Bolognia, it is long and you will hate reading it some weeks, but it will provide you with an excellent foundation. Your residency will likely have a textbook schedule, try to stick to it as best you can. As you read and go to lecture, pick one notebook/book where you will write all of your high yield facts. The Derm In-Review binder is a great study system and you can update it every year. It is difficult at first to determine what is high-yield but if someone says this is good to know or you feel like it is an important fact write it in your little book. You will get the hang of picking out what is important and if you write too much you will figure out a way to expand your notes so, don't stress out about the factoid being high yield enough. This way you have all of your high yield notes in one place. This book will become the most important thing to you as your residency goes along.

You will be very happy you did as a second year.

As a second year, I would recommend reading Andrews, it is full of wonderful pearls and you are able to build on the foundation that you created with Bolognia. This is the best time to read Andrews because third year will be extremely busy. Additionally, reviewing Spitz and Wolverton are recommended. Then third year, all you need to do is review and focus on the boards which consists of looking at as many kodachromes as possible – the Derm In-Review website and Kodachrome app are excellent study tools for this – doing as many questions you can get your hands on, going over path glass slides and using the virtual atlases and then reviewing your notes in your high yield book by making flash cards or whatever works for you. There are also many high yield board review courses that are definitely worth going to, at least one. Each year, it is recommended to attend the 60 dermatopathology timed slide review at the American Academy of Dermatology.

It is amazing how fast third year flies by so it is very important that you have prepared yourself during the first two years of residency. Third year is so busy. Because you are interviewing for fellowship or jobs, you are negotiating a contract. You are moving to your new location, you are trying to finish your resident research project and get all those papers final submitted. Believe me there are about a million different things that will eat away at your time during third year.

Lastly, as a first year you definitely need to save money to be able to afford third year. Third year is extremely expensive between paying for the boards, $2500 to register, $250 for hotel and $500 to fly. Review courses- even if you only go to one it will likely be $1000 all in all, and then add in moving, licensing, license registration and DEA costs. The amount of "extra" money you will need is extraordinary. Unless you know to save for it you may be stuck eating peanuts all of third year because they are all required costs.

The Landscape of Private Equity in Dermatology and Concerns About Private Equity-Backed Models

BY SAILESH KONDA, MD, FAAD

Private equity (PE) is one of the hottest topics in dermatology right now. I knew nothing about PE during my residency and fellowship training. I entertained the possibility of working for a PE-backed group after my fellowship training and even shortly thereafter. However, after talking to many colleagues, I saw the light and walked away from the PE-backed model. I became fascinated with PE and began researching its landscape and potential long-term impact on our specialty. Dr. Joseph Francis had been analyzing CMS data since it was first released in 2014 and was looking into outliers and the ethics of corporate dermatology. We decided to join forces and ultimately developed a cohesive talk.

Our initial findings were presented to our residents and faculty during a Grand Rounds at the University of Florida in December 2017. The lecture was well received and has been given in a variety of local, regional, and national settings over the course of the last year. We also formed the Group for Research of Corporatization and Private Equity in Dermatology and recently published an article in the Journal of the American Academy of Dermatology on the subject, which was

featured in the New York Times. As time is the limiting factor in sharing our knowledge, I am pleased to publish my first delivery in a 2-part series, offering our perspectives on PE to residents and early career dermatologists reading Next Steps in Derm.

Overview

As of November 2018, there are 33 known PE-backed dermatology groups, two of which are now defunct. Twenty-five of these 33 PE-backed groups were newly formed or acquired in 2015 or thereafter. These PE partnerships are often via practice management agreements. This allows them to circumvent the AMA Corporate Practice of Medicine Doctrine and any corresponding state laws. Interestingly, the largest dermatology management companies, many of which are PE-backed, formed a coalition called the Dermatology Practice Support Alliance in May 2016. These coalition companies collectively own a majority of the corporate dermatology market. Herein, I will highlight five out of ten concerns about PE-backed models.

Five Out of Ten Concerns About PE-Backed Models

PE has a finite time horizon for a specific return on investment

Bain & Company summarized the ultimate goal of PE: "All PE firms want to create value as quickly as possible – to grow revenue and take out cost – and a strong playbook helps to accomplish that." PE firms typically have steep fees – they take up to 2% of the assets under management and 20% of profits above the "hurdle rate," which is the expected return for investors.

Dermatologists lose autonomy

"cogs & widgets"

Always remember the difference between a profession and an occupation. Non-physician managers in corporate dermatology groups may have significant responsibility and authority over physicians. There are reports of non-physician managers dictating patient care. Dermatology is a profession – not an occupation.

PE leverages physician extenders

PE-backed dermatology groups may employ physician extenders on a larger scale given their lower compensations compared to dermatologists. Physician extenders may be leveraged to the maximum extent allowable by state law with varying degrees of supervision.

Difficult to mix PE and optimal, ethical patient care as the goals of each are inherently conflicted

The New York Times article from November 2017 and the recent MarketWatch article from June 2018 offer a glimpse into the future of dermatology if PE firms with specific financial timelines continue to infiltrate our field and compromise our Hippocratic oaths. In response to growing concerns, the AMA passed a resolution in June 2018 to examine the effects on the healthcare marketplace of corporate investors, including PE firms.

PE has a longstanding history of boom-bubble-bust cycles

PE has a history of boom-bubble-bust cycles across all industries since the 1980s. Despite touting theoretical economies of scale, many practice management companies failed overnight in the 1990s. PE is experiencing another boom because the stock market appears overvalued, hedge-funds are offering mixed results, and interest rates are low. Furthermore, PE has one trillion dollars awaiting investment, which may lead to practice overvaluations.

Billing in Dermatology: A Quick Overview of Coding Modifiers

BY LINDSAY STROWD, MD

Correct dermatology billing and coding can be challenging due to the number of in-office procedures performed by dermatologists. The second part of this series will provide a quick overview of some of the more commonly utilized modifiers. Used to communicate what was performed to insurance providers.

One of the more frequently used and poorly understood modifiers is the "25" modifier. According to the Centers for Medicare & Medicaid Services (CMS), the definition is: a significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service.

The "25" Modifier

What does this truly mean? Physicians will often attach a "25" modifier to any E/M code if a procedure is performed in the same visit. This is incorrect and can result in an audit. The "25" modifier can only be applied to E/M codes. The best way to conceptualize the "25" modifier is to subtract a procedure from a visit, and see what documentation remains. Physicians often forget included in procedure codes are pertinent history, discussion of treatment options, performing the procedure, and followup care.

The "24" and "79" Modifiers

The "24" modifier is used to indicate a separate E/M encounter during a postoperative period of a prior performed procedure. The "79" modifier is used to indicate the performance of a separate and unrelated procedure during a post-operative global period. For example, a patient who underwent Mohs with graft repair develops a rash two weeks later. The physician would need to use a "24" modifier to the office visit for the rash to indicate to insurance that this is a new and separate issue from the previous surgical procedure. If that same patient required a skin biopsy of the rash, the provider would need to use both "24" and "79" modifiers to indicate a separate office visit with a separate procedure from the graft repair.

The "59" Modifier

The "59" modifier is attached to CPT codes to indicate a procedure or service was distinct or separate from other services performed on the same day. For example, if a patient undergoes cryosurgery of 4 actinic keratoses and a shave biopsy of a mole, the biopsy CPT code 11100 would require a "59" modifier. If three procedures are performed in a single office visit, the "59" modifier would need to be applied to the second and third procedures listed. Due to perceived overuse of the "59" modifier, CMS developed four new modifiers which became effective as of January 1st, 2015.

These modifiers include: XS, XP, XU, and XE, and can be used in place of "59". The "XS" modifier is most pertinent to dermatologists and is used to represent two procedures performed in the same encounter. But on different organs or structures. For dermatologists, this would mainly be used to indicate different anatomic locations on the skin.

Keep this article handy for quick reference and you'll be prepared to code.

By doing a little research and keeping up with modifier changes, you'll know you're coding them correctly. So you can get paid for the work you've performed.

Next Steps in Derm Content Highlights

Derm In- Review Pop Quiz

Each Friday, a new Pop Quiz question is posted to the Next Steps in Derm website, courtesy of Derm In-Review! Test your knowledge each week with these questions!

Patient Buzz Series

Do you ever field odd-ball patient questions and wonder where the information they presented came from? The monthly "Patent Buzz" series addresses recent dermatology news from the consumer press and provides background on the conditions and treatments your patients may ask about at their next office visit. Find the latest in the series under the Derm Topics section or by clicking the QR Code.

JDD Editorial Highlights

Check out editorial highlights each month from the *Journal of Drugs in Dermatology (*JDD), as well as podcasts and the "Ask the Investigator" series.

Genoderms Made Ludicrously Easy: Tumor Syndromes Webinar:

Dr. Finch brings a special webinar presentation from his wildly popular book, Genoderms Made Ludicrously Easy. In this webinar, Dr. Justin Finch reviews the clinical spectrum of genetic disorders with malignant potential and examines key dermatologic clues to the diagnosis of genetic tumor syndromes, including PTEN hamartoma syndromes, Reed syndrome, Gardner syndrome, Rombo syndrome and others. The discussion of important clinical features is facilitated by high-yield visual mnemonic cartoons.

NEXTSTEPS IN DERM

NextStepsinDerm.com

Explore Career Building Resources

Next Steps in Derm Guidebook and eGuide
Written by an esteemed faculty of key opinion leaders (KOLs) and industry professionals

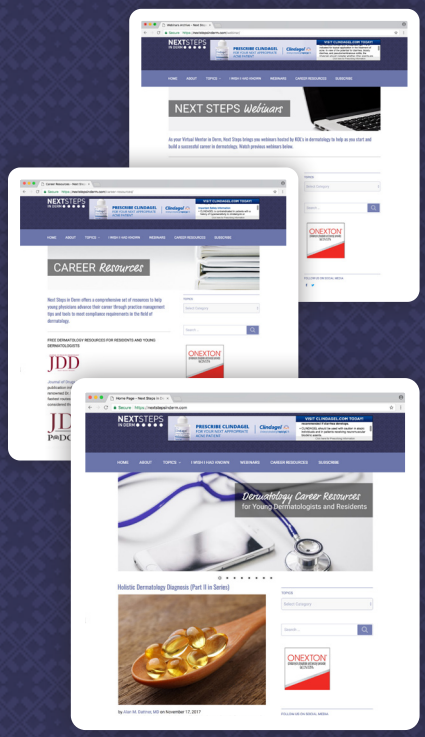
Online Resource Center
Exclusive articles, downloadable podcasts, career planning tools

Monthly eNewsletter
Expert direction and advice from your mentors

Live Webinars & Q&A
Join in for a series of interactive sessions with key opinion leaders in the industry

"Best Of" Booklet
Review top articles from the website as well as exclusive practice management content written by a seasoned practitioner

Newsfeed
Your one-stop resource for the latest news in dermatology and practice management



Your #derulife goals are calling!

- ~~Graduate med school head of the class~~
- ~~Score dream residency position~~
- Pass boards
- Find niche in derm
- Negotiate contract
- Open a practice
- Live the #derulife

Sponsored by Pfizer

@NextSteps_Derm @nextstepsinderm @NextStepsinDerm