Executive Decisions in DERMATOLOGY

ADAM

September/October 2013

[Click Here for Helpful ICD-10 Links!]

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Click here for an easy to use guide!

In this issue:

ICD-10 Strategies
By Angela D. Short, MHA, CPCO, CPC-D

The compliance date for ICD-10 is October 1, 2014, and if you are like most administrators you are likely feeling overwhelmed and asking yourself what you should be doing to prepare your office now. While the answer is not cookie cutter for all practices, think back to the strategies that you deployed to prepare for Y2K and 5010 and use this as a roadmap. As an industry, ICD-10 will likely have greater impact to your practice than 5010. Unlike 5010 where practices relied on computer vendors and clearinghouses to be ready, ICD-10 has the making for a perfect storm that could have a significant impact on cash flow. With ICD-10, every single diagnosis code that your provider selects, and you enter into the practice management system will change. Not only will the actual code change, but the number of codes available for a single diagnosis could go from one option to eight or more! If you have not started your ICD-10 planning and training, you should not delay another day because the amount of work ahead is exhausting. What can you do now to prepare for ICD-10? Here is one strategy to consider:

Plan ahead for emergency cash.

How will your practice survive if insurance payments stop for a week, a month, three months? Many practices felt the cash crunch under 5010, so this should be a lesson to plan ahead with extra cash available. If your practice cannot afford to put cash aside to make sure the practice can continue to operate for up to three months without insurance reimbursement, then the practice needs to consider a line-of-credit that can be tapped into in an emergency situation. Depending on the practice's cash needs, you cannot wait until the practice is facing a cash crunch to seek financing because the due diligence from the bank standpoint could take some time. If a line-of-credit is the best option for your practice, you should start the process no later than January 2014, and have the line in place no later than July 2014.

Due diligence with health plans, practice management software vendors and clearinghouse.

Most health plans have articles in their monthly newsletter updating healthcare providers regarding the plan's ICD-10 readiness. It is very important to stay on top of major plan's progress, and when the plan expects to start testing ICD-10. The same is true if you use a clearinghouse.

If your clearinghouse has not already sent out communications regarding their ICD-10 preparedness, with clearly established timelines for testing, then you need to reach out to the clearinghouse in writing and ask at least the following questions:

- When will the clearinghouse be able to accept claims with ICD-10 codes?
- Will the clearinghouse be able to handle both ICD-9 and ICD-10 claims, and submit these to payers as they demonstrate compliance with handling ICD-10 claims?
- What testing is currently underway?
- What is the testing schedule with major health plans? For example: Medicare, Blues, Aetna, Cigna, etc. (Understanding when the health plan communicates they will be ready to test is important to understand.)
- Is the clearinghouse able to convert ICD-9 codes to ICD-10 if the provider is only able to submit ICD-9?

Ask the following questions from your practice management software vendor:

- When will the system be ready to handle the alpha-numeric ICD-10 codes?
- Can our practice have both ICD-9 and ICD-10 codes loaded into the practice management system? While this may seem like a straight-forward answer, never be blindsided because you did not ask what

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appears to be obvious.

- Does the vendor have a tool to automatically crosswalk the ICD-9 to the ICD-10 codes? More than likely most vendors will use a file load to add ICD-10 codes, but it never hurts to ask.
- When will the vendor start testing with the clearinghouse?

Understand your current coding trends.

Run a report from your practice management system that provides every ICD-9 code that you have billed over the last year that provides a unit count on how often the code has been billed. A sample report may look like the sample below:

ICD-9-CM	Units	Percent of Total
629.9	XX	22%
238.2	XX	13%
702.0	XX	8%
706.1	XX	7%
078.10	XX	3%

From this report, start with the top ten ICD-9 codes that likely represents a significant portion of your practice's coding, and go to the ICD-10 crosswalk to understand the number of new diagnosis codes that are available. For example, 706.1 is a common code in dermatology used for acne. This same code in ICD-10 has eight different options including:

L70.0	Acne Vulgaris
L70.1	Acne Conglobata
L70.3	Acne Tropica
L70.4	Infantile Acne
L70.5	Acne Excoriee Des Jeunes Filles
L70.8	Other Acne
L70.9	Acne Unspecified
L73.0	Acne Keloid

Our office holds weekly meetings with the billing office staff where one ICD-9 code is reviewed in detailed and staff is provided a handout that itemizes the ICD-10 code with a definition of each diagnosis. Additionally, we review the documentation requirements and anticipated denials associated with selecting an unspecified diagnosis. Using the acne example, it is very tempting just to select L70.8 Other Acne since the definition is exactly the same as 706.1, but expect health plans to use ICD-10 as a tool to revamp local medical review policies, and generic acne diagnosis may no longer support injections or other services provided to the patient, resulting in denials.

Documentation considerations.

While some providers document very detailed notes, in the current healthcare environment, providers are challenged to meet all the demands placed on them, and they often compromise detailed chart notes with other priorities in the office. With ICD-10, the documentation requirements will be an even greater priority, and the provider can no longer skimp on his/her chart note. Additionally, in offices with electronic health records, it is easy for providers to get into a habit of marking specific data elements that could result in documentation being inconsistent with a diagnosis selection. For example, Acne Conglobata is a severe form of acne that causes large, painful, pus-filled cysts deep in the skin. If the template only offers mild, moderate, and severe and on today's episode the provider selects mild because he/she meant that the breakout is mild for this particular patient, then an explanation would be warranted.
It is never too early to start training physicians about the documentation demands of ICD-10, and how their lack of documentation could result in claim denials. Start with the provider's top ten diagnosis codes and share with the physician the additional diagnoses that will be available. Solicit feedback from the provider how he/she would document each diagnosis differently, and ensure that your templates include the language to support the variation. As the templates are updated, share with the physician the availability of the additional information, and encourage the provider to start using the new language today so he/she is not in such a crisis come compliance time.

Other considerations.

If your practice currently uses a paper superbill, you will need to update the superbill with ICD-10. Because of the additional number of codes, it is unlikely that most practices can include all the necessary codes on a

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single page. While it may be simple to turn a sheet over and mark a second page, this will take additional time for your providers. Assume this extra task takes 30 seconds to complete, and your office sees 45 patients a day, this is 22 ½ minutes on average per day. How will the office handle this extra time requirement? Will the office space out the time the patient comes into the office? Will the provider hold his/her charge tickets until the end of the day? (NOT recommended) Will the office allow the patient to wait extra time to complete this administrative task? This is a consideration that needs to be addressed.

Educate…educate…educate.

Educating providers and office staff is the most important initiative that the office will undertake. Each office's approach to education may be different but every office should make it their number one priority over the next year to ensure all applicable staff and providers become proficient with ICD-10 demands.

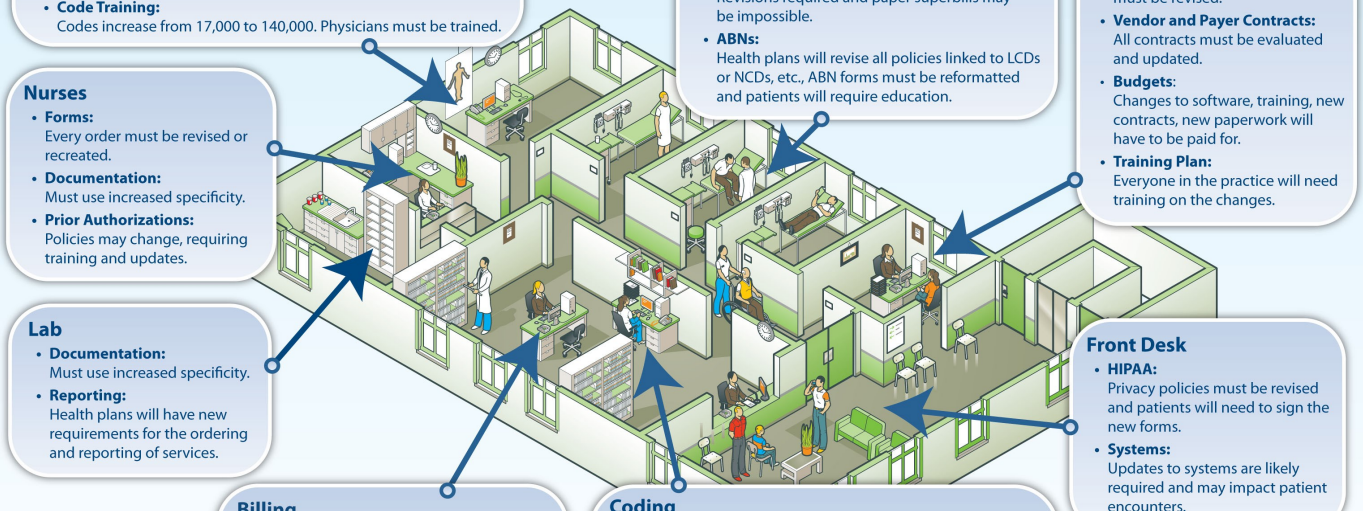
Angela Short, MHA is the Revenue Management and Corporate Compliance for The Dermatology Group. Her practice has seven locations in New Jersey. Angela is a Certified Medical Practice Executive, Certified Professional Coder, and Certified in Healthcare Compliance. She is an active ADAM member and serves on the Communications and Networking & Mentoring Committees.

Developed by AAPC, the diagram below shows how to transition each member of your staff.

ICD-10 Will Change Everything

Will You Be Ready?

AAPC can help every aspect of your practice's transition to ICD-10. Whether you just want the basics or need complete implementation training, AAPC has a solution to fit your needs.



Physicians
- **Documentation:** The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training:** Codes increase from 17,000 to 140,000. Physicians must be trained.

Clinical Area
- **Patient Coverage:** Health plan policies, payment limitations, and new ABN forms are likely.
- **Superbills:** Revisions required and paper superbills may be impossible.
- **ABNs:** Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted and patients will require education.

Managers
- **New Policies and Procedures:** Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts:** All contracts must be evaluated and updated.
- **Budgets:** Changes to software, training, new contracts, new paperwork will have to be paid for.
- **Training Plan:** Everyone in the practice will need training on the changes.

Nurses
- **Forms:** Every order must be revised or recreated.
- **Documentation:** Must use increased specificity.
- **Prior Authorizations:** Policies may change, requiring training and updates.

Lab
- **Documentation:** Must use increased specificity.
- **Reporting:** Health plans will have new requirements for the ordering and reporting of services.

Front Desk
- **HIPAA:** Privacy policies must be revised and patients will need to sign the new forms.
- **Systems:** Updates to systems are likely required and may impact patient encounters.

Billing
- **Policies and Procedures:** All payer reimbursement policies may be revised.
- **Training:** Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

Coding
- **Code Set:** Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge:** More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use:** Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved.

www.aapc.com/icd-10

AAPC

ICD-10 Quick Links:

ICD-10 transition in depth

http://www.aad.org/members/practice-management-resources/coding-and-reimbursement/icd-10/icd-10- transition-updates

Gives an overview of ICD-10 including background, ICD-9 and ICD-10 comparisons and additional resources.

ICD-10's list of FAQ

http://www.aad.org/members/practice-management-resources/coding-and-reimbursement/icd-10/icd-10-faqs

Lists ten frequently asked questions, including the comparisons between ICD-9 and ICD-10,

ICD-10 tips

http://www.aad.org/members/practice-management-resources/coding-and-reimbursement/icd-10/icd-10-tips

The changes in ICD-10-CM are in its organization and structure, code composition and level of detail. This new ICD-10CM structure will allow for further expansion that was previously not possible with ICD-9-CM as more positions in more chapters are left open and available for future modifications. To see examples, click on the link above.

ICD-10 Codes

http://www.aapc.com/ICD-10/icd-10-codes.aspx

AAPC has several resources beyond their ICD-10 implementation and coding training, including FAQs, reference guide, white papers and so much more.

Top 50 Codes for Dermatology (Fast Forward to ICD-10)

http://www.aapc.com/icd-10/crosswalks/icd-10-dermatology.aspx

The ICD-9 to ICD-10 crosswalk for dermatology helps you see how broad diagnoses explode out to several specific diagnoses in the new system. Identify how the 50 most frequently used diagnostic codes for Dermatology will be mapped to ICD-10. The easy-to-use three-page laminated crosswalk sheet maps from ICD-9-CM to ICD-10 with the information needed to report codes for your most common services.

About ICD-10

http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10

Gives numerous links to planning, timelines and other resources.

Association of Certified Dermatology Techs (ACDT)

Introduction to ICD-10 Training Video

http://icd10dermatology.com/icd10-training-video/

President's Corner

A series about the state of the Association and what's new with ADAM. Do you have a question for Jayne? Email us at ADAMinfo@shcare.net

The summer days are now behind us, and the time is here to jump into the important tasks at hand. With the September 23rd deadline of the New Omnibus Rule and next year's ICD-10 implementation, everyone is hard at work. ADAM is knee deep in planning for the 2014 Annual Meeting and developing excellent resources, from social media to webinars, for our membership.

Sincerely,

Jayne M. Kresinske

Member Spotlight

Would you like to nominate someone for the Member Spotlight? Email us at ADAMinfo@shcare.net

ADAM: *What is your name and where do you work?*
Linda: My name is Linda Leiser and I am the Practice Manager at Charlottesville Dermatology, in beautiful Charlottesville, Virginia. We have 2 physicians, 1 Nurse Practitioner and 1 Laser Technician. Our primary focus is general dermatology, with a small cosmetic component. My practice sees 100-120 patients a day, so we are very busy.

ADAM: *When did you join ADAM?*
Linda: Within my first year of starting at this practice, so about 5 years.

ADAM: *How long have you been a practice manager?*
Linda: I have been around a long time, 25.5 years. I am from Scotland and when we moved here I had not worked for 15 years. I went knocking on doors at offices nearby. I have three children and I wanted to be close to home in case of emergencies. I was hired as a receptionist at a Pediatric office, near my house in Raleigh, NC. I was there for 10 years and moved through the various jobs. During the late nineties, when practices in North Carolina were being bought by Integrated Medical Companies, I served as a Regional Director, overseeing several Pediatric Practices for about three years, focusing on operations and IT. One of the most exciting challenges I have had was starting a Centralized Billing Office in Northern Virginia. It was incredibly hard work; from putting together workstations, telephone systems, computer systems to bringing on new practices, setting up protocols and gaining their confidence. I mistakenly thought with my last move, the pace in dermatology would be a little bit slower. WRONG!

ADAM: *As a practice manager, what do you find to be the most challenging part of your job?*
Linda: Where to start? I have been around long enough to remember the day of ledger cards, peg boards and "taking care" of patients and life was so much simpler.

As a manager of a small practice, I wear many hats. I manage most of the accounting, retirement plans, facility, HR, IT, travel planning, marketing as well as mothering the staff and overseeing Practice Operations. I am fortunate to have a **SUPER** Billing Manager who has followed me to different jobs since 2001. I don't have to worry too much about claims and denials. She has that under control.

There are three challenges for me.

1. Managing the expectations and the work ethic of younger staff members.
2. Staying current with all the changes in healthcare and finding the time to listen to a webinar on changes.
3. Managing the expectations of physicians who do not understand the details of how much work it takes to make even a small practice run smoothly.

ADAM: *What would you recommend to a member who is looking to be more involved?*
Linda: I would recommend the following:

1. Attend the conference. The last conference had something for all levels of experience. I have attended MGMA in the past. It is so anonymous that you feel like a tadpole in a goldfish pond. ADAM has well rounded topics, but drills down to the impact on Dermatology. I like that.
2. Network, Network, Network! The peer support is important for your sanity.
3. Join LinkedIn. There are great ideas, comments and suggestions every day and it only take a minute to read.
4. Volunteer for a committee. I have been amazed how rewarding that has been and how much I learn from my peers.

Protect Yourself on Pinterest

By Mike Sacopulos

Pinterest has become a popular marketing tool for medical practices to promote their products and services by posting images for others to comment on and share. In short, Pinterest is a mecca for sharing images. Users can find what they like and file it away without the clutter associated with an actual bulletin board.

There are countless reasons why practices have been turning to Pinterest. The site has more referral traffic than LinkedIn, Google+, and YouTube combined. It is not surprising that 68.2% of Pinterest users are women and 28% have an annual household income of $100,000. Pinterest is in growth mode with no end in sight. La Jolla Cosmetic in sunny southern California uses the Pinterest powerhouse to promote services ranging from breast augmentation to chemical peels.

Staff at La Jolla Cosmetic have been actively using Pinterest for a couple years, but it wasn't until recently when their Director of Patient Services, Janelle Robinson, personally dipped into Pinterest herself.

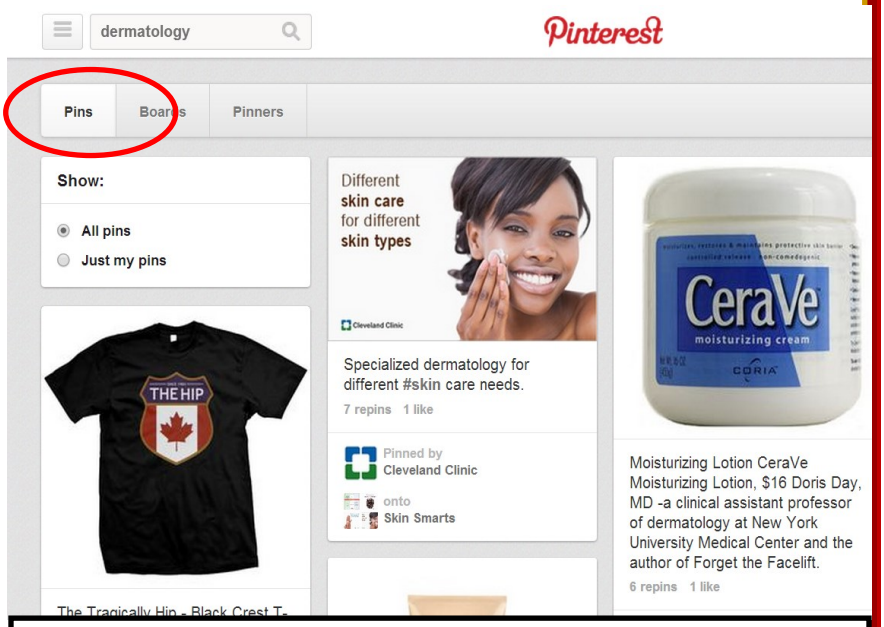
"There are so many things you can do for your life and home," Robinson said.

Robinson eventually found herself creating a dream board, a trend she has found many of the patients she connects with online do as well.

"It becomes your vision of what you want. Maybe our clients don't have the money for what they want right now, but they can pin their vision/ dream for a time when they are ready to take the next step," Robinson said.

Pin It to Win It

To hone in on the patients passion for Pinterest, La Jolla Cosmetic decided to hire Cosmetic Social Media manger Monique Ramsey to further engage their marketing potential on Pinterest. One of their first missions was to encourage more patients to sign up for La Jolla Cosmetic's new loyalty program called Renew Advantage. The loyalty program works much like a membership to Costco's where the person had to pay for the membership for the year, but will save on everything they do and buy. To achieve more members, La Jolla Cosmetic ran a "Pin It to Win It" campaign on Pinterest.



A **pin** starts with an image or video you add to Pinterest. You can add a pin from a website using the Pin It **bookmarklet** or upload an image right from your computer. Any pin on Pinterest can be repinned, and all pins link back to their source.

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What is Pinterest?

Pinterest helps people collect and organize the things they love. Here's how it works for you; The pin cycle, Beautiful boards, Simple discovery, and A Network of interests. Click here to learn about Pinterest basics.

Are you interested in having your firm join Pinterest?

Pinterest or Business has the resources and tools that you need to get started at http://business.pinterest.com/.

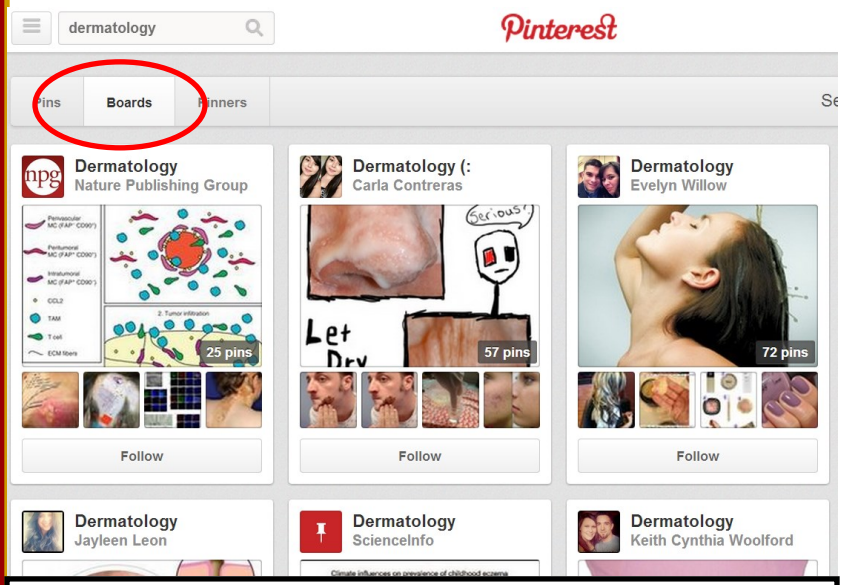
"We made an example board of what we wanted on La Jolla Cosmetic's Pinterest page. We gave each contestant some things they had to do to qualify, for example follow La Jolla Cosmetic on Pinterest, create a board called Renew Advantage and a board containing at least 20 images of how they viewed the word *renew*," Ramsey said.

As participants started to share their images by pinning them to their board, all of the people who follow that participant saw their pins and, in turn, guided to La Jolla Cosmetic's website. Winners of the "Pin It to Win It" campaign won a one year membership to the Renew Advantage membership program.

Problems with Pinterest

With popularity comes caution as to the use of the popular site. Pinterest users can become vulnerable to lawsuits, if they don't have permission to use the content.

Most risks from Pinterest to physicians in medical practices come from two areas: photographs and professional responsibility for advertisements. Just remember physicians open the door for a claim anytime they improperly pin or post an image on Pinterest. Here are some things medical practices need to do to stay safe when using Pinterest.



A **board** is where you organize your pins by topic. You could pin ideas for remodeling your bathroom to your House Projects board, for example. Boards can be secret or public, and you can invite other people to pin with you on any of your boards.

Whose Photo Is it?

Do not use photographs taken by others without their expressed written permission. Photographers can own copyrights to their photographs. Do not violate someone else's copyright by posting their photographs without their permission.

Posing Before and After Photographs…

By using photographs taken in your practice, you avoid the potential problem of violating someone else's copyright, but the problems do not end there. You need to have your patient's permission to use the photograph of him or her. I recommend that you specifically note that the photographs maybe placed in an electronic format where you no longer exercise control over them. This disclosure is important because it gives fair warning to the patient that they cannot later change their mind and revoke permission, thus causing the photos to come down. Once photographs are on Pinterest they will be electronically "pinned" on other users boards, thus being outside of your control.

When posting before and after photographs on Pinterest, you should also use language that states "individual results may vary" or "results not typical". These statements need to be employed because of recent attention from the National Advertising Division (NAD) and the Federal Trade Commission (FTC) specifically the NAD which recently issued a decision regarding Pinterest. NAD began following NutriSystem Inc.'s weight loss stories that claimed great success and linked back to the NutriSystem website. The NAD found that it was undisputed that these "pins" represented customer testimonials and as such the "pin" should be accompanied by clear and conspicuous disclosure noting that typical results customers can expect to achieve using the NutriSystem weight loss program. The NAD and the FTC have taken particular interest in social media sites such as Pinterest, so be careful.

Professional responsibilities when promoting your practice

By utilizing sites such as Pinterest, physicians are promoting their practices. This means that their activities need

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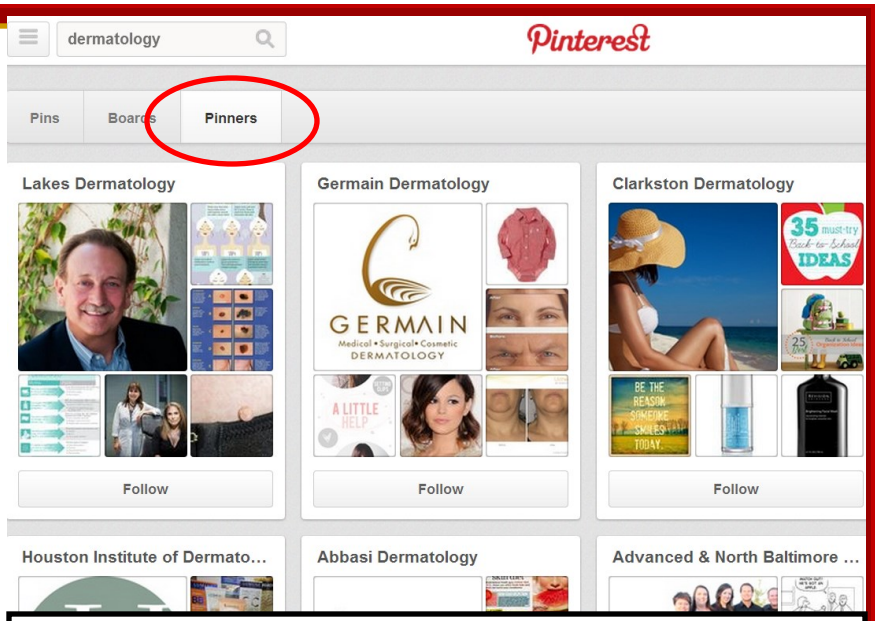
to comply with their relevant boards of medicine. Boards of medicine have rules of professional responsibility for physicians when advertising or otherwise when promoting themselves. These rules vary by state. For example, some states find that it is not permissible to use before and after photographs of your patients even with their permission. All states would agree that a physician cannot make fraudulent statements about their ability or patient results. Before placing anything on Pinterest, it is best to do a quick review of the physician's responsibilities and obligations as set forth by their licensing board(s).



A **pinner** can create several boards. You can follow a pinner or a specific board.

"You just have to do a little research up front to make sure what they are doing will comply across the board with your society, your state medical board and the platform you are using. I have seen on Facebook where a company will say, the third person to hit the "like" button will get a free Botox. You can't do that because that would go against Facebook's rules.

You can't use an action of Facebook to get a prize. It is also against some society rules to give Botox away to someone you have not had a consultation with," Ramsey said.

Only the paranoid survive…

Assuming that you have your patient's permission and that you're permitted to do so by the licensing board, you still want to protect yourself. Here are some useful tips for owners of photographs when placing them on Pinterest.

- Include copyright statements on your website
- Include code on your website that prevents an image from being copied
- Consider including a watermark on your images

Image owners who do not want their material shared on Pinterest can add a small piece of Pinterest-provided code to their website that prevents Pinterest users from sharing that site's content.

Pinterest states they follow the Digital Millennium Copyright Act (DMCA) to ensure they are in compliance with all copyright laws. The DMCA divides websites into two categories: service provider and content provider. Service providers are websites like Facebook, Twitter and Pinterest. Content providers create content. The DMCA provides a safe harbor for service providers. Therefore, when a user violates copyright laws, the service provider 'Pinterest' can choose to follow the DMCA safe harbor provisions and not be held liable for the actions of the user.

Given the popularity of Pinterest and the demographics of its users, many aesthetic practices will be interested in using this site, but being aware of the areas of concerns stated above, physicians should be able to move forward safely.

Michael J. Sacopulos is the CEO of Medical Risk Institute (MRI). Medical Risk Institute is a firm formed exclusively to provide proactive counsel to the healthcare community to help providers understand where liability risks originate, and reduce or remove these risks. He may be reached at msacopulos@medriskinstitute.com.

Preparing for the Federal Sunshine Act

By: Bruce Armon and Karilynn Bayus

On August 1, 2013, certain pharmaceutical manufacturers and GPOs were required to begin collecting data to comply with the Physician Payments Sunshine Act ("Act"). The Act was discussed in an ADAM webinar on July 17, 2013.

Under the Act, certain manufacturers of drugs, devices, biologics, or medical supplies covered by Medicare, Medicaid or CHIP must report on an annual basis specific direct and indirect payments or transfers of value that they made to physicians. These first reports are required to be made to the Centers for Medicare and Medicaid Services ("CMS") by March 31, 2014 for the period from August 1 through December 31, 2013, with the results to be published online by CMS on September 30, 2014. Thereafter, reports are due by the 90th day of each calendar year.

The Act requires applicable manufacturers to report remuneration to physicians and teaching hospitals above the de minimis amount of $10 per payment or $100 in the aggregate for a calendar year. The "de minimis" thresholds will be adjusted in subsequent years based upon the change in CPI.

The Act requires the following information to be reported and included as part of a CMS database:

- the name and address of the physician;
- the amount and form of payment or other transfer of value;
- date of payment or transfer of value;
- the nature of payment; and
- the related covered drug, device, biological or medical supply.

The Act includes seventeen (17) categories for "nature" of payment. There are special reporting rules for research payments, continuing education programs, and food and beverage.

The Act excludes certain items from the reporting obligations including product samples and educational materials directly benefitting patients.

As practice managers, you will play a very important role in ensuring compliance with the Act and minimizing potential negative publicity relating to the disclosures. You should do the following:

- Understand what the Act requires, and what will be disclosed about the physicians in your practice;
- Set up a compliance framework for your practice;
- Talk to the manufacturers who visit your practice to make sure they understand the Act;
- Be aware that the media will review the Act's CMS database; and
- Recognize that federal and state investigators will review the Act's CMS database.

The Act and its goal of transparency will have intended and unintended consequences for dermatology practices and their physicians. Be prepared to act and react accordingly.

Bruce D. Armon is a partner and Karilynn Bayus is an associate in Saul Ewing LLP's Health Practice and they provide transactional, regulatory and compliance assistance to medical practices and physicians, and other health care providers. They can be reached at barmon@saul.com and kbayus@saul.com.

Going Cosmetic
By Glenn Morley

This is Part 2 in a 3-part series exploring the integration of cosmetic services into a dermatology practice.

For physicians who have decided to incorporate cosmetic services into their established dermatology practice, the early planning stages are like a honeymoon. Managers and physicians engage in lively discussion about creating a medical spa or aesthetic center. New skincare lines are road tested by staff. Lasers are contemplated. And "coming soon" is the excited response for all cosmetic inquiries. During this phase it's easy to look at the move toward cosmetic services through idealistic, rose-colored glasses.

But incorporating cosmetic services requires more than just excitement and brainstorming sessions with vendors. Good planning and a drive to success are essential. So before you send out e-blasts for open houses and Botox nights, focus on foundational nuts and bolts. Even your earliest aesthetic patients must get a 5-star experience when they visit your website, call for information, or come in for a consult. You get only one chance to make a first impression.

1. Define your 'inner guru.'

In today's competitive aesthetic world, you've got to define and 'own' your particular expertise in cosmetic dermatology. Which procedures do you want to be known for? What services differentiate your practice? How are you, the physician, different than your competitors, and why should patients choose you?

When you are excellent at what you do, the marketplace will buy or finance what you are selling. Ten thousand Baby Boomers turn 65 each day; that's a big opportunity for physicians able to articulate their value and deliver a great patient experience and great clinical results. How you define your 'inner guru' is the first step toward developing both.

2. Don't just dabble. Be committed to cosmetic.

"Dabbling" in cosmetic medicine does not build a loyal patient base or long term cosmetic relationships. Few things shout "dabble" as much as keeping a cosmetic patient waiting. Before scheduling the first cosmetic patient, think through existing patient processes and determine how you'll cater to cosmetic patients, not just dabble with them. Carve out a defined time in your schedule for injectable sessions, laser sessions, and cosmetic consultations.

Dabbling dermatologists can also make the mistake of not taking the office décor and patient experience up a few notches. Don't be one of these. Ensure the reception room furniture and furnishings are up-to-date. Send staff to customer service training. Add polish to communication materials and fee quotes. And make sure everyone from physicians to staff is well groomed and dressed neatly and professionally.

3. Create a team of disciples with accountability.

Many practices focus all of their energy on training a handful of staff members to interact and communicate with cosmetic patients. This is a mistake. While it is great to have a "point person" available for key activities such as fee quoting or answering in-depth questions, all staff and providers must believe in, and be able to, articulate your expertise. There can be no room for doubt or hesitation when it comes to talking about you as the cosmetic dermatology guru to see.

Further, dividing staff into cosmetic and non-cosmetic groups can be divisive among the team. At some point in their journey with you, patients interact with almost every staff member – from front desk to billing. Confidence, gratitude, and expertise must be on display by all staff, at all times. There can be no weak links. Every team member must be counted on to channel some passion when asked by a patient, "Is he (or she) any good?"

Those who fail to get with the program of integrating cosmetic services with general dermatology can become resented by staff that have, and should receive additional training or discipline. Those unable to make the "cosmetic cut" are not the right fit for your new practice.

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4. Prepare talking points and scripts.

"Secret shopping" of dermatology practices reveals that staff often rushes to provide callers and patients with prices instead of first communicating the practice's unique service propositions and value points. This is not staff's fault if they have never been provided with what to say or how to say it. Both of these things matter and both can be taught.

Don't put staff in the position of making up talking points on the fly. Anticipate this essential training need by working as a team to create scripts that promote you as the most talented, artistic, and experienced cosmetic dermatology 'guru' who anyone seeking cosmetic rejuvenation should schedule with. And make it a point to provide details about financing options in the script. Copay and deductible increases have encouraged both cosmetic and medical patients to investigate special healthcare financing options. Patients have a lot of questions, and staff can best serve them by capably explaining how healthcare financing works as well as explaining your skills and value. Providing training for service elements and the nuts and bolts of financial options is an investment in garnering positive patient reviews at online rating sites, and great word of mouth referrals.

Glenn Morley, practice management consultant with Karen Zupko & Associates, analyzes practices and advises physicians and managers on operational, financial, personnel and marketing strategy and tactics. Look for the next article from Glenn Morley in this "Going Cosmetic" series in the next newsletter. All statements and opinions in this article are the sole opinions of the author and not those of CareCredit, GE Capital Retail Bank. The content is subject to change without notice and offered for informational use only. You are urged to consult with your individual advisors with respect to any professional advice presented. Your receipt of this material constitutes your acceptance of these terms and conditions.

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