SKIN CANCER IN PRIMARY CARE

A PRACTICAL GUIDE

Professor David Wilkinson

Paul Elmslie

LIONCREST PUBLISHING

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I dedicate this book to my patients and the doctors that have taught me all that I know. Our patients let us into their lives and trust us with their health. For me, it is a privilege and an honour to serve them. As doctors we help and teach each other. I was taught skin cancer medicine by a small number of caring and skilled general practitioners, and in turn I have tried to share what I know with my colleagues. Thousands of doctors have attended my course over the last several years, and if each has learned and applied one useful lesson as a result, it is all worth it.

My family, friends, and colleagues provide me with great support and allow me to pursue my career to the best of my ability. I am indebted and grateful more than they can ever know.

– David Wilkinson

My passion for skin cancer medicine came after seeing a 31-year-old mother of two die unnecessarily due to a lack of access to costly specialist care and an overburdened public hospital system. If her GP had the basic skills to detect and treat skin cancer, this situation might have been prevented.

I would like to thank all the doctors and specialists who have taught me about skin cancer medicine and then made their time available to teach many more GPs these essential skills through our company, HealthCert International. One of our core values is "Making a Difference". I believe we are doing this.

Another special group is the doctors, nurses, and staff who worked with me over the years to build and run skin cancer clinics. Your contributions have led to the business methodology shared in this book.

To achieve your life goals requires the support of family and friends. Your unconditional support for what I want to achieve is something I am thankful for every day, especially my children Sasha, Jessica, and Alisha.

– Paul Elmslie

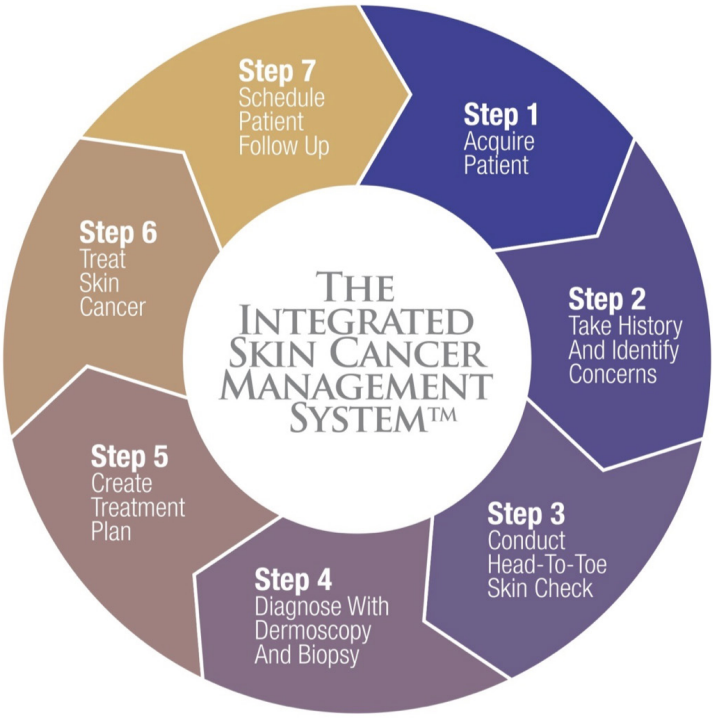
PROLOGUE

THE SKIN CANCER WORKFLOW

Skin cancer in primary care can be daunting for general practitioners. Most didn't receive a great deal of education or training in this field during their undergraduate studies or at a registrar level. The lack of knowledge leads to wastage in the healthcare system, with GPs either just cutting out anything that looks suspicious or referring every patient with a skin lesion concern to a specialist. This wastes the time of dermatologists, creates unnecessary delay and worry for patients, and adds the cost of unnecessary procedures to the healthcare system and the patient.

Skin cancer is not overly complex. As it is one specific area of one system of the body, the workflow and decision-making process for diagnosis and treatment is relatively simple. To help illustrate this, we developed the 'Integrated Skin Cancer Management System™'. This step-by-step approach will assist you in making sure that nothing is missed and your patients receive the best of care within your practice.

Step 1. Acquire patient
Step 2. Take history and identify concerns
Step 3. Conduct head-to-toe skin check
Step 4. Diagnose with dermoscopy and biopsy
Step 5. Create treatment plan
Step 6. Treat skin cancer
Step 7. Schedule patient follow-up



Of course skin cancer can be a little more complicated or steps skipped. For example, if a patient was referred to a specialist then they may treat the skin cancer but, as the patient's referring doctor, you have a duty of care to ensure they receive adequate treatment.

WHY SKIN CANCER MATTERS

Skin cancer matters.

Each year, about 1500 Australians die from melanoma; another 500 die from non-melanoma skin cancer. Many many thousands undergo treatment for skin cancer. That is why skin cancer matters.

Skin cancer is by far the most common cancer in Australia. Eighty per cent of all newly diagnosed cancer cases are skin cancer. Recent statistics show that two out of three Australians will be diagnosed with skin cancer by the age of 70. Melanoma is the fourth most common cancer and the most common cancer in Australians aged 15 to 44. Every year, about 1 million non-melanoma skin cancers are treated. The cost to the government is over $600 million per year just in direct Medicare funding. The total cost of diagnosing and treating skin cancer is much higher.

Skin cancer is so prevalent in Australia for several reasons. A high proportion of the population is of Anglo-Celtic heritage, and their skin isn't well adapted to living in the southern hemisphere at a low latitude. Australian culture plays a key role: we have a culture of being active outdoors. Until recently, wearing sunscreen or taking sun protection measures was actually culturally seen as a sign of weakness. Many people being diagnosed with skin cancer today grew up putting on baby oil or coconut oil and lying on the beach effectively until

they blistered. Most of the skin cancer that we're diagnosing and treating today is caused by damage that was done around 20 years ago. The aging population means that the number of skin cancer cases and the need for treatment is only going to increase.

The Slip Slap Slop skin cancer campaigns introduced by the Cancer Council Australia more than two decades ago have been very effective in creating awareness around sun protection measures to prevent skin cancer. And although there is some evidence that per capita rates of melanoma are stabilizing or even falling, for the foreseeable future, the number of skin cancer cases is only going to increase as the population ages and grows in total size.

Why This Book?

Patients trust their doctors and often listen to what we have to say. We have a critical role to play in promoting effective prevention strategies.

GPs are on the front line of skin cancer diagnosis and treatment in Australia. We play a vital role in skin cancer medicine. We are the gatekeepers to the rest of the healthcare system. We should aim to treat as many patients in primary care as we can, within our own scope of practice and levels of expertise. We should be able to diagnose the large majority of skin cancers. We should carefully co-ordinate the care that all our patients need and deserve.

The reality is that the very large majority of patients with skin cancer in Australia can, and should, be diagnosed and treated in primary care. Equally, a large number of patients need referral to additional expertise, whether that be in primary care or other specialist medical practice. Advances occur all the time, and major improvements are occurring in the medical management of advanced melanoma right now. It is incumbent upon us, as GPs, to be aware of these advances and ensure that our patients have access, as needed.

This book is for the mainstream GP—the GP who sees a full range and spectrum of patients in primary care. All such GPs

will see patients with skin cancer. The aim of this book is to give you highly pragmatic advice, guidance, and even instruction on how to diagnose skin cancer, treat it within your practice if possible, and refer the patient to specialist care if necessary.

The book does not aim to be comprehensive—it specifically does not provide you with every nuance and option. We aim to give you evidence-based guidance on what to do, using a firm foundation of proven practice that will keep you and your patients safe.

PART 1

GETTING ORGANISED

In the first part of this book we focus on getting you and your practice organised so that you can treat patients with skin cancer most effectively and safely. We focus first on how to set up your practice. We then consider important medico-legal issues so that you and your patients remain safe, and we then explore the causes and prevention of skin cancer.

Throughout this book we take a straightforward and pragmatic approach. The recommendations we make are all evidence-based, use national treatment guidelines, and are referenced. We contextualise these recommendations based on Professor Wilkinson's clinical practice over the last decade or more, together with the feedback we have gained from teaching thousands of doctors over the last decade.

Our approach therefore is "do this". We aim to give you proven advice—a way to practice. We expect you will use this as a baseline, and build and adjust your own approach from there.

The discussion of setting up and running a skin cancer service is based on Mr. Elmslie's experience operating skin cancer services in primary care practices and dedicated skin cancer clinics. The goal in this section is to highlight what we consider the essential tools and processes to deliver quality care for your

patients. Many new technological innovations, most notably, stand-alone image-capturing systems, could be included in your practice. As these are expensive and not seen as core tools, we have excluded them from this section.

CHAPTER 1

PRACTICE ORGANISATION

A typical GP surgery and consulting rooms can easily be set up to add skin cancer screening and treatment to the practice. Minimal additional equipment is needed; existing examination and procedure rooms can be used. The cost of purchasing the few extra tools you need isn't significant in real terms. You will use these tools for years into the future.

Basic Elements

You need some basic elements in your practice to ensure you give yourself the best opportunity to identify and diagnose lesions.

For your consulting room, the essential items are:

- Good lighting
- Magnification
- High-quality dermatoscope (also called a dermoscope)
- Punch and shave biopsy kits
- Adhesive bandages
- Cryoflask

On the list of nice to have but not essential are:

- Camera with dermatoscopic attachment
- Hyfrecator or diathermy machine (highly recommended)

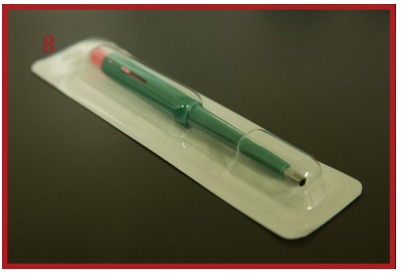
For your procedure room (which could be your consulting room if you don't have a dedicated procedure room), the essential items are:

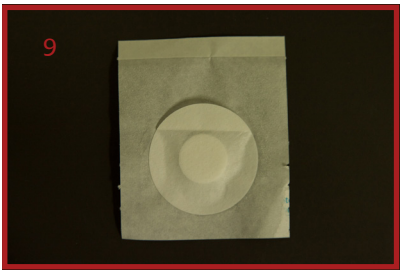
- Heavy and fine instrument kits
- Punch and shave biopsy kits
- Cryoflask
- Hyfrecator or diathermy machine

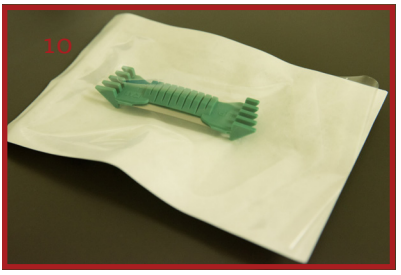
On the list of nice to have but not essential is:

- Camera for before and after image capture

BASIC ELEMENTS







1. High quality dermatoscope
2. Cyroflask
3. Camera with dermascope
4. Hyfrecator
5. Magnifying glass
6. Fine instrument kit
7. Heavy instrument kit
8. Punch biopsy
9. Adhesive bandage
10. Shave biopsy

The Procedure Room

The first important consideration in setting up your practice to treat skin cancer is to have good illumination in the consulting room. If you can't see the skin well, you're not going to be able to find lesions, particularly the smaller ones. You need a good-quality dermatoscope with built-in illumination. You will also want to have a modesty blanket for your patients. That's really all you need to do a thorough, head-to-toe skin check.

You will also need some other instruments and tools for diagnosis and treatment:

- Cryotherapy flask. This is a pressurised flask that holds liquid nitrogen used for cryotherapy.
- Punch biopsy set-up. This should contain local anaesthetic along with the appropriate needles and syringes. The punches usually come in sizes ranging from 3 to

8 millimetres; the kit contains scissors for snipping the base of the specimen. A flexible blade for shave biopsies should also be in the setup. The pathology company the practice uses usually supplies these tools to you.
- Pathology specimen container. The specimen is placed in the formaldehyde, the jar is sealed and accurately labeled, and sent on to the pathologist the same day.
- Adhesive bandages for stopping the bleeding and covering the punch wound.

In the procedure room, typically we have fine and heavy procedure packs. These contain scalpels, forceps, scissors, needles, and needle holders. The fine pack is for procedures in cosmetically sensitive areas, such as the face. The heavier pack is designed for procedures elsewhere, such as the trunk.

For both punch biopsies and excisions, the instruments are simple and relatively inexpensive. If you plan to do regular skin sessions, say half or a full day once a week, that would mean doing multiple biopsies and other procedures. In that case, you're going to need an adequate supply of instrument packs. You obviously don't want to run out of essential surgical tools whilst you're in the middle of doing procedures. If you sterilise your instruments on site, which is what most practices do, it's important to have a good system for making sure you have enough sterile equipment on hand.

Many practices are now choosing to only use fully disposable instrument packs, so you might want to consider this option. Personally I wouldn't recommend it, as the quality of the tools is inferior, but it depends on how many procedures you're doing and whether you have a steriliser onsite. If you have a steriliser onsite, you should definitely have your own instrument kits.

With any instruments, you have the choice between purchasing high-quality instruments from a known manufacturer that has been around for a long time, or purchasing cheaper versions or lower-quality instruments. We've found, based on our years of experience building many practices that focus on skin cancer,

that quality matters. In general, good-quality instruments will last for ten years or longer. If you buy cheap instruments or disposable instruments, you'll find they'll be less easy to use, which will make procedures a bit more difficult. You'll end up throwing them out more.

If you're only doing one or two procedures a week, then you may not need or wish to invest in expensive tools. But if you're already doing some procedures and know that side of your practice is likely to grow, invest in good tools that will last for a long time. Bear in mind that the tools are a tax deduction for the business. When amortised over ten years, the cost is almost nothing.

The Dermatoscope

Possibly the most important tool in skin cancer diagnosis is the dermatoscope (also called a dermoscope). We recommend investing in a high-quality dermatoscope. Once again, this is an essential tool you will purchase and use for many years to come. It requires no calibration or additional maintenance. Essentially a dermatoscope is simply a handheld, 10X magnifying glass with LED lights. The main difference in dermatoscopes is that the lower-quality products use batteries that you have to replace and their iris/field of vision is smaller. They're typically not as well made, so they're more likely to break because they're made out of plastic. The higher-end products are made of metal, have a larger field of vision, are rechargeable, and connect to cameras easily. If you're considering making skin checks a regular activity in your clinical practice, we strongly suggest buying a good quality one. We also recommend buying it for yourself and not for the practice. As when you need the one the practice has, chances are you won't be able to find it and/or the batteries may be dead. Instead, purchase a rechargeable dermatoscope that you find comfortable to use.

We urge you to use the dermatoscope on a very regular basis to review suspicious lesions, even if the patient hasn't attended your practice for a skin check. It will lead to incidental discoveries of melanoma and help save lives.

Consulting Room Set Up

The consulting room in a normal general practice is basically the same as for a skin cancer practice. The only real difference is that you would want the skin cancer trolley with the cryotherapy flask and everything you need for biopsies to be readily available in the room.

Because a skin check involves looking at the whole body, the position of the examination couch is important. A skin check can be done with the patient standing, but most doctors prefer to do the check on the examination couch. In most general practices, the couch is up against a wall. Sometimes that's because there's just not adequate space in the room to be able to place it away from the wall. But if at all possible, we recommend that you relocate the examination couch with the head against the wall in a way that lets you walk almost completely around it. Consider replacing any old fixed beds with hydraulic beds that let patients get onto them more easily and more safely. These beds let you adjust the height to what's most comfortable for you when doing a skin check.

Typical consulting room set up

Good lighting is essential for a good skin check. Almost all practices use fluorescent tube lights in the ceiling. Swap out any older tubes for modern daylight fluorescent tubes. These radiate at a wavelength that is close to sunlight, which is the best light for seeing the skin. Ceiling fluorescent lights may leave the exam room with shadowy areas and will cause shadows on the skin of the patient. It may be possible to change or move the light fixtures to give you better, more even lighting. If that's not practical, an adjustable floor lamp with a daylight bulb is helpful. Your magnifier and dermatoscope have lights that will eliminate shadows in the areas you examine.

Biopsy Set Up

The biopsy trolley is simply a resource that has all the items you need to be able to conduct a punch or shave biopsy quickly in your room. We suggest a set up as shown in the image below. Items included are:

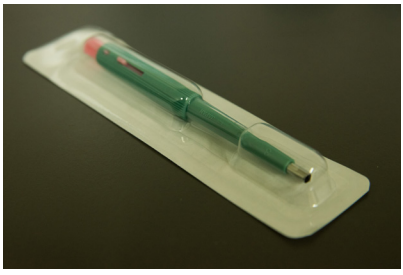
- 3, 4, 5, 6 and 8mm biopsy punches
- Flexible blade shave biopsy kit
- Scissors
- Insulin syringes
- Adhesive bandages
- Local anaesthetic
- Biopsy sample jars
- Medical waste bin

We suggest keeping a cryoflask on the trolley as well, but this could be anywhere in your room. The trolley is typically positioned next to the examination area, so it's easy to simply turn away from the patient and access the items you need to conduct the biopsy. This will optimise your productivity.

Sterilisation Procedures

Sterilisation is a good example of why it's important to buy good quality equipment. If a practice conducts procedures of any sort, having a steriliser is highly recommended. You

Tray set up in consulting room to allow cryotherapy, biopsy and dressings



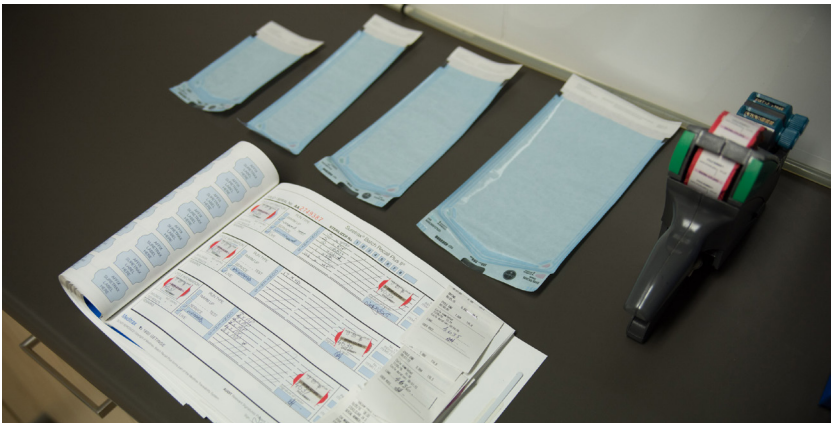
Punch biopsy tool

Shave biopsy tool

can buy a good quality one second-hand. It's very important to have a tracking system for the sterilisation process. The standard practice is to keep a logbook. Every individual packet of instruments has a unique identifying number that's recorded in the book. Once the steriliser cycle is complete for each packet, then a print-out reading showing the steriliser reached the minimum required temperature and time by the Australian Standards in a steam steriliser of 133 degrees for 3 ½ minutes is put in the logbook.

When the procedure is conducted, the unique sterilisation identifier is recorded in the clinical notes. If for some reason

On-site sterilisation unit



Recording sterilisation processes is essential

in the future, a claim is made as to the sterilisation of the instruments, you have a documentation process to track instruments and verify they were sterilised. It's very important that the tracking system be effective and simple to use. If a good system isn't already in place in the practice, companies that can supply those resources are available to help. An alternative is to use disposable packs only.

Referrals

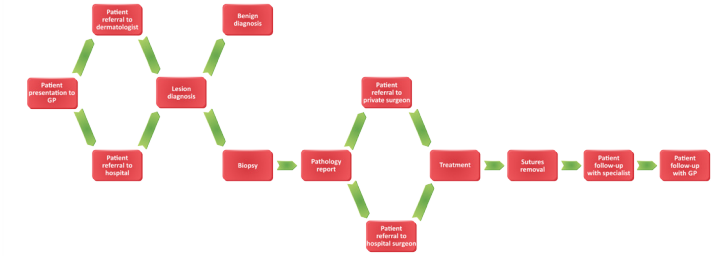
When you have completed some basic dermoscopy training and own a dermatoscope, you will start looking at patient's skin more regularly for suspicious lesions. As you start doing more skin cancer screening, you are going to find more lesions. Some of these you will have the confidence to manage in your practice, but many will be outside your comfort zone and will need to be referred on. You are almost certainly going to make more referrals as you upskill in skin cancer medicine.

GPs who manage skin cancer patients should have good referral pathways. Ideally, you will have a good working relationship with a nearby dermatologist so that when you have a patient with a suspected melanoma, that patient will get seen quickly, instead of being put on a long waiting list. Similarly, good relationships with general surgeons and plastic surgeons will pay off for your patients. Having those pathways will help make sure your patients get fast treatment.

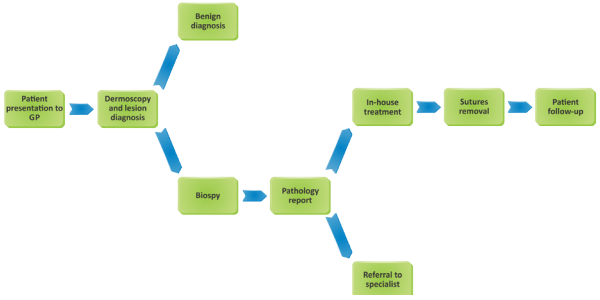
The other referral pathway is to the public hospital. As GPs, we need to be mindful that the public hospitals often categorise skin cancer in two ways. One is melanoma, and the recommendation or the goal is to try to treat those patients within 30 days. Then there's non-melanoma, or category three cases. Most public hospitals in Australia have a year-long waiting list for these cancers. What we need to be very mindful of is that a third of all skin cancer deaths come from non-melanoma skin cancer. If a patient has an aggressive SCC, you wouldn't want them on a waiting list. Patients will also have to live with the anxiety related to having a skin cancer that hasn't been definitely treated yet.

Your third option is referring your patient to a dedicated skin cancer clinic, or a GP with a special interest in skin cancer. This area has grown because, given the lack of access to specialists and the long public hospital waiting lists, GPs with a special interest and training in skin cancer have stepped in to fill a need. These clinics may be the place to refer complex patients who can't afford the plastic surgeon or who you don't want to wait for months to be seen.

GP referring to specialists or hospital



GP managing skin cancer within own practice



Comparison of primary care model and specialist / hospital model for skin cancer diagnosis and management

Primary Care Model	Specialist / Hospital Model
Patient's out-of-pocket expenses can be between $0 to $300	Patient's out-of-pocket expenses can be between $0 to thousands of dollars
Patient waits on average two weeks from initial discovery to definitive treatment	Patient waits on average two to twelve months from initial discovery to definitive treatment
Patient runs the risk of misdiagnosis due to GP's lack of training in skin cancer management	Patient experiences anxiety and runs the risk of dying while waiting for diagnosis and treatment
Fast, efficient and low-cost care for the patient with minimum cost and waste of resources for the health system	Maximum cost for the health system and significant waste of resources on office-based treatments

At a skin cancer clinic, patients are treated typically within a two-week time period, with little or no out-of-pocket cost. The follow-up is done by the patient's original GP. The service is fast and costs less than the alternatives.

As a GP, the key concern around referring patients to a skin cancer GP or someone who works in a skin cancer practice is probably your comfort with the doctor's training and skills. You're referring the patient because you're not comfortable managing the problem, so you want to make sure the doctor you refer them to does have the right skills. As there are now formal certificate, diploma, and master of medicine courses in skin cancer available, you can check if the doctor you may wish to send your more complex patients to has participated in these post graduate programs. Within your medical community, you can easily discover who has a reputation for good results. And of course, you'll see the results when the patient comes back to you after treatment.

If you refer a patient to a specialist, public hospital, or the like, you have a duty of care to ensure the patient attends and gets the appropriate treatment. This is very difficult to manage unless you have excellent recall systems (discussed below) and is another reason why upskilling to minimise unnecessary referrals is of great advantage to you.

Why Upskill?

If your patient base has a lot of patients over age 65, you're likely to see a lot of skin cancer in people who need to have a low-cost or free management option. To help these patients most effectively, you can upskill yourself.

GPs with an interest in skin cancer who start having a regular schedule for skin checks will probably find one or two cases a week that are significant. Patients talk in their community, and if you find a melanoma, that grateful patient will tell everyone to go see you for a skin check. In our experience, your skin cancer practice will start growing rapidly. The biggest challenge to doctors is, "Where do I make it stop? Do I now do two days of skin cancer, three days of general practice?" We've seen many

doctors who upskilled to handle skin cancer as way to help their current patients end up doing nothing but skin cancer. There's simply so much skin cancer in Australia that the patient demand exceeds the doctor supply.

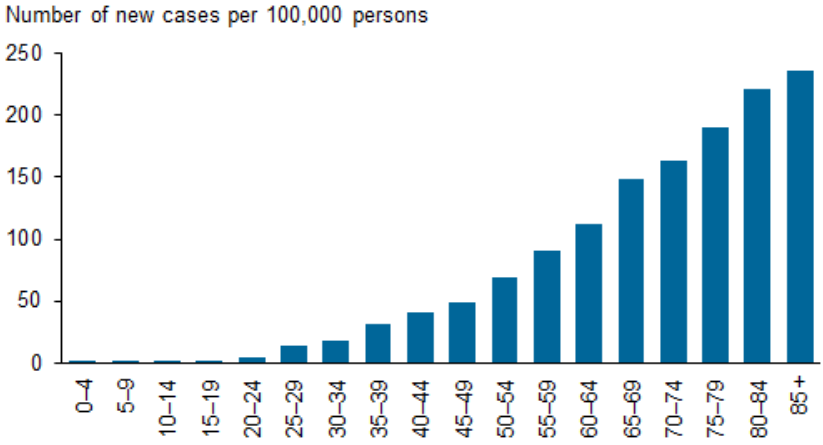
Upskilling and obtaining some sort of university or other accredited post-graduate award is of great benefit. It shows to your peers, colleagues, and patients that you have had additional training specifically in the area of skin cancer. They will all feel more confident in your skills. There are plenty of different courses that you can take now to upskill. Choose them carefully and you will be making a positive investment in your career. For a list of courses available to primary care doctors and nurses, please visit the companion website at www.primarycareskincancer.com.

Example certificate

Marketing Your Services

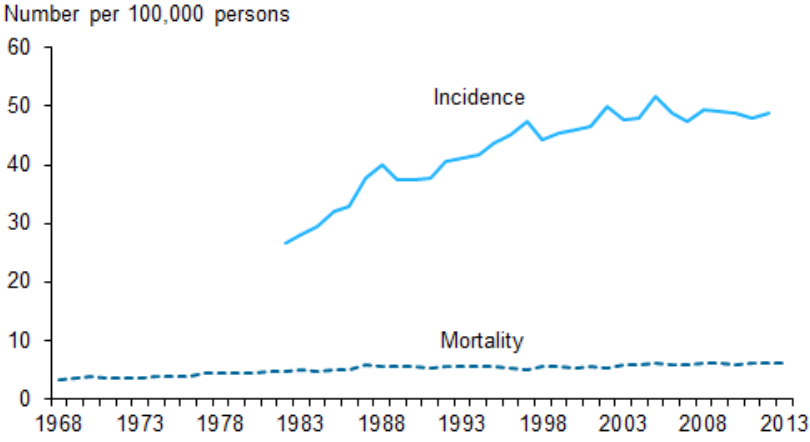
In a general practice environment, you don't need to market skin cancer care externally to patients at all. Cases are walking in and out your door every day. The only reason they're not being managed is because no one's looking, finding, and then managing them. We're not suggesting you should be doing a routine skin examination on every single patient, but certainly it should be suggested where appropriate. Awareness of skin cancer is high. If you make your patients aware that you now have a skin cancer screening service on a regular weekly basis, many patients who have been putting off a skin check for whatever reason will then book an appointment with you.

A regular skin cancer screening session within your clinic has many benefits, including providing your staff a place to book your skin check patients and allowing you to spend the time to conduct a head-to-toe skin check without pressure. Marketing is as simple as a notice in your waiting room.



Estimated age-specific incidence rates for melanoma skin cancer, 2016

Source: AIHW analysis of the Australian Cancer Database https://melanoma.canceraustralia.gov.au/statistics#source1



Age-standardised incidence rates for melanoma skin cancer 1982–2012 and age-standardised mortality rates for melanoma skin cancer 1968–2013

Source: Australian Institute of Health and Welfare. Australian Institute of Health and Welfare 2016. Australian Cancer Incidence and Mortality (ACIM) books: pancreatic cancer. Canberra: AIHW. [Accessed January 2016].

You can also market within your practice by making sure your colleagues know you have an interest in skin cancer and have taken some additional training. They will then refer patients with lesions of concern to you at your regular skin cancer sessions. Sending a patient down the hall as an internal referral, instead of an external referral onto a long waiting list,

is definitely preferable for the practice and the patient.

Skin cancer treatment may be quite seasonal. In some parts of Australia, such as Queensland, people are aware of skin cancer because the sun is out 300 days of the year. GPs in these areas deal with skin cancer year round. In more temperate parts of the country, skin cancer awareness coincides with the summer months. Any communication to your patients around skin cancer should be focused during those months. That also coincides with the timing of the Slip Slop Slap awareness campaigns. Focus your marketing on your older patients, those age 65 plus; the next group would be the patients age 50 plus. These are the people with the longest history of sun exposure and thus the greatest risk of skin cancer. When you create marketing materials, these are the people to target.

When marketing to older adults, the key thing to understand is that they don't want to know they've got cancer. What they would like to know is that they *don't* have cancer—they want that peace of mind. When you market your services, talk about how a 15-minute skin check is simple, quick, efficient, non-invasive, and will give them the peace of mind that they don't have skin cancer. Anyone who turns up to your practice to get a skin check isn't there because they really want to be. They want to know that they can get a quality examination and reassurance that some area of concern on their skin isn't something to worry about.

Any marketing you do must be in accord with the ethical and professional guidelines set by AHPRA. We'll discuss those in detail in chapter 2.

Billing

Many medical practices in Australia today take only the standard government rebate (bulk billing), even though rebate freezes mean that amount hasn't kept pace with price increases. Some practices have moved to a mixed billing model. In mixed billing, part of the charge is the government fee for particular age groups and part is privately charged. Many specialists simply do private billing only.

When you're a GP billing Medicare, a skin check is considered a consultation. It's based on time. Depending on how long you take to do your skin check (typically, that should be around 15 minutes), it's billed as a standard consultation with an item code. Please note that Medicare does not rebate for screening unless there is a specific or general concern. Ensure your clinical notes document the reason for the patient's attendance. If the patient has been directed by their employer to get their skin checked, as an example, these checks can't be billed to Medicare and need to be paid for privately.

If you do a biopsy, it's billed as a specific item number 30071 and it has no time applied to it. Whether it takes you two minutes or 22 minutes, you get paid the same. It's the same for procedures. This is where you realise the importance of having an efficiently set-up room and the right support systems and the right people around you to optimise your productivity.

Because biopsies are billed as a procedure, we recommend doing them at the same time as the skin check. You're able to bill for the skin check, which is a consultation, and the biopsy, which is a procedure, at the same time. However, if you bring the patient back to discuss the negative results of the biopsy or the results of any excision, you can't charge a consultation to Medicare-though you can charge the patient (but most doctors don't). If the biopsy is positive and the lesion requires further treatment a consultation can be charged.

For example, let's say you find a suspicious lesion during a skin check, biopsy it, find out that it's a BCC, and schedule the patient for surgery. The consultation where you explain the results of the biopsy to the patient and they agree to surgery can be billed to Medicare. Anything after the surgery, such as dressing changes and suture removal, also can't be charged to the government. Anything you do post-procedure is considered to be part of the surgery and is included in the fee the government pays you.

You can—of course—still charge the patient for activities. What we normally do with our procedures is charge a private fee on top of the bulk-billed rate; we take the pre- and post-side of it into consideration and charge a single amount.

The billing for procedures is based on what is it you're treating, where it is on the body, and then how big it is. Those three defining factors determine the exact code you should use to bill for that patient. Typically, it's fairly simple.

Full details are in the Medicare Benefits Schedule, which is available online (www.mbsonline.gov.au). A summary of the skin cancer relevant item numbers including a downloadable one-page sheet of all the numbers, is available on our website at www.primarycareskincancer.com.

A crucial aspect of billing is that your clinical notes must match your billing codes. If you do a particular procedure on a lesion that's 1.5cm, that would have to be in your clinical notes. Medicare fraud is tantamount to tax fraud. The government has significant resources to investigate you if they're concerned that you're taking advantage of the Medicare system. The best protection you have is that your clinical notes match the billing you have submitted to the government and to the patient.

Patient Billing

How much should you charge the patient out-of-pocket for your medical service? This is difficult because it's subjective. We suggest making out-of-pocket expenses for procedures simply a function of time. We charge $200 an hour on top of whatever Medicare pays for the surgical procedure. If it's a 30-minute procedure—a simple SCC excision, say—the patient would be out-of-pocket $100.

The reason we've chosen to walk this particular path is that most patients just want to know how much money they're going to have to contribute. It's relatively easy for the staff to know that if it's a 30-minute procedure, then we will charge $100 out-of-pocket. The patient's clear on their costs in advance. Everyone else is clear as well. The fee is irrespective of what the pathology is, what the size of the lesion is, and where it happens to be on the body.

One of the benefits of doing a biopsy prior to doing a procedure is if the biopsy is positive and an excision procedure is needed, we can bill for the procedure the same day we do it, because we

already have a pathology test result that tells us what the lesion is. Before the patient has a procedure, we can tell them exactly how much it's going to cost and we also know exactly what we're managing clinically (especially helpful for determining the required margins). We can manage the patient correctly by filtering out benign lesions and unnecessary excisions and offering alternatives to surgery. Our goal is to have only cancer cases proven through biopsy sent to our procedure room, unless of course it's a suspected melanoma that we will excise with thin margins initially.

Receptionist plays a key role in patient engagement

As concerned physicians, we want people to get their skin cancers treated even if they can't afford it. For some patients, $100 is a real hardship. As a physician you need to have some flexibility in your billing so that everyone who needs treatment gets it. We're also flexible about multiple lesions. When a patient needs several lesions that need to be removed we usually only charge privately for the first one or two. Make sure the patient and your staff know what the billing should be and try to have a uniform policy in the clinic. You don't want to have different doctors charging different fees, as patients do talk and can cause a negative reaction no matter how good the clinical outcomes!

What we've found from experience is that GPs don't like talking about money. It's not why they went into medicine. They'd much prefer someone else, like the practice manager or reception staff, to talk about fees with the patients. That's fine. Try and make sure the discussion about payment arrangements is held more privately and not at the front counter in front of the whole waiting room as the patient leaves.

Medicare Coding Caveats

When you add skin cancer care as a part of your general practice, you need be aware of the way that billing procedures for with Medicare can impact billing for consults soon after the procedure has occurred. In particular, you need to have a very good understanding of two codes: NRTP and NNAC. NRTP means Not Related To Procedure. NNAC means Not Normal After Care.

Remember, when you do a procedure, you cannot subsequently bill for a consultation with the patient to discuss anything about the procedure. But what happens if the patient comes back to you for something not related to the procedure? How does the government know that you're not billing for a discussion of results but rather for something that's got nothing to do with that particular procedure? To distinguish the two visits, you would use the code NRTP, Not Related To Procedure. Let's say a regular patient has an excision done on a BCC. Three days later, she's back in the clinic, not because of the excision but because she needs to get a script filled for her cardiovascular medication. Very clearly, that visit has got nothing to do with the excision three days earlier. You need to add NRTP to the consultation billing.

NRTP is relatively simple—it's the code for something that's got nothing to do with the surgical procedure you just did. As long as you put in your consultation item number and NRTP on that billing, it will go through successfully.

NNAC—not normal after care—is a bit more complex. Firstly we have to define what is normal after care. By definition, normal after care is what you put in your clinical notes when you did the procedure. If you said to the patient, "Just come back in 10 days to get your sutures out", and then the patient decides to come in and get the wound checked out on day three, that's not normal after care, because that's not what you determined it to be at the time of the procedure. Not normal after care usually means wound infection or complications, such as a suture line that splits open. The decision to come in earlier than anticipated is almost always made by the patient. If the patient comes in or there's some sort of complication or wound breakdown, you can bill a consultation

for those services. However, you must use the NNAC coding within 10 days of the procedure if you want the billing to be processed.

Recall Systems

A critically important aspect of skin cancer medicine is having efficient recall systems. The main reason is that we want to make sure we don't have any patients slip through that definitely need medical help. The simple example would be the patient who has a melanoma diagnosed but then doesn't attend for the definitive excision. Another would be a pathology result of a skin cancer biopsy, but the patient then doesn't turn up for the surgery. The final example would be sending three pots with samples to your pathology lab but getting only two reports back.

All of these situations, whilst very rare, have enormous risk to the practice and patient. Practices handle this differently but a simple system is a logbook which the staff uses to record pathology and incoming reports. In our practice we print out pathology forms for upcoming procedures so that if a patient doesn't attend the practice, we have another piece of paper as a reminder we need to take action. The last area where you need a good system for is referrals out of the practice, as you have a duty of care to make sure the patient attends and gets the appropriate care. Whilst this is very difficult you do need to have a process, whether in your clinical notes or a manual system, to make sure patients do attend other physicians.

Medical Notes and Shortcuts

As discussed above in the billing section, your clinical notes are the basis by which you determine the item numbers you bill the patient and Medicare. The other important value of your clinical notes is that they also provide you medico-legal protection (this is discussed further in chapter 2).

Medical notes in skin cancer medicine don't need to take you a great deal of time, because the processes, as shown in the prologue, follow a uniform path. For example, when we conduct a skin check, we will either find a suspicious lesion or not. This element of the consultation could be documented as such:

- Patient presented with suspicious lesion [insert location].
- Patient consented to full head-to-toe examination but no other suspicious lesions were detected.
- Visual examination of patient's presenting complaint and further with dermoscopy revealed a [insert lesion name].
- Patient assured and appropriate follow-up recommended.

This could all be built into a template within your clinical notes software and given a shortcut code. Make sure you find out how to build shortcuts in your medical software and take the time to populate it. The time spent now will save you hundreds of hours in the future.

As a simple list, you want to create templates for:

- Skin check: nothing found
- Skin check: something found
- Punch biopsy: location and size
- Shave biopsy: location and whether deep or superficial
- Cryotherapy
- Lesion removal: location, size, suture used, and method of closure
- Dressing change
- Suture removal

TEMPLATES FOR CLINICAL NOTES:

these can be set up within medical records software for regular use

FULL SKIN CHECK

PHx: - Nil Significant
FHx: - Nil Significant
Med: - Nil
Allergies: - Nil Known

Concerns: Nil
Findings: Full Skin Check
No significant lesions detected

Action: Information Sheet - "Skin Cancer"
Advice about skin protection

Notes to Reception:
Appointment: Review in 12 Months
Billing: Bulk Bill
Claim: PROCESS
Discharge: Item No: 23,

OT - REMOVAL OF LESION

1. ^

ROL - ^ mm diameter PE
LA - (10:1) - 1% Lignocaine with Adrenaline (1:100,000)
- NaHCO3 (8.4%)
Ellipse
[Suture at 12 o'clock - Reference point = Nasal Bridge]
Pathology - S&N
Closure - Skin - ^/0 Nylon - Subcuticular / Interrupted
- Subcut - ^/0 Vicryl
Dressing - Fixomul / Opsite
ROS / Results ~ ^ Days

Notes to Reception:
Appointment: ROS Clinic in ^ Days
Billing: Bulk Bill
Claim: PROCESS
Discharge: Item No: 312 ^ ,

OT - SHAVE BIOPSY

1. Shave Bx
^
LA - (10:1) - 1% Lignocaine with Adrenaline (1:100,000)
- NaHCO3 (8.4%)
Pathology - S&N
Dressing / Wound Care instructions

Notes to Reception:
Appointment: Results in 1 Week
Billing: Bulk Bill
Claim: PROCESS
Discharge: Item No: 30071,

OT - PUNCH BIOPSY

1. PBx - 3 mm
^
LA - (10:1) - 1% Lignocaine with Adrenaline (1:100,000)
- NaHCO3 (8.4%)
Pathology -
Dressing / Wound Care instructions
Results ~ 1 Week

Notes to Reception:
Appointment: Results in 1 Week
Billing: Bulk Bill
Claim: PROCESS
Discharge: Item No: 30071,

OT - CURETTAGE

1. Curettage -

LA - (10:1) - 1% Lignocaine with Adrenaline (1:100,000)
- NaHCO3 (8.4%)
Cautery to base
Pathology - S&N
Dressing - Solosite / Opsite / Bandage
Results ~ 1 Week

Notes to Reception:
Appointment: Results in 1 Week
Billing: Bulk Bill
Claim: HOLD BILLING
Discharge: Item No: 30196,

OT - FULL THICKNESS SKIN GRAFT

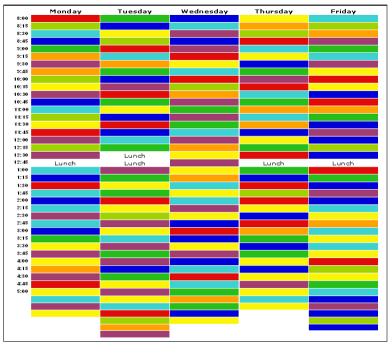
1. ^

ROL - ^ mm diameter PE
LA - (10:1) - 1% Lignocaine with Adrenaline (1:100,000)
- NaHCO3 (8.4%)
[Suture at 12 o'clock - Reference point = Nasal Bridge]

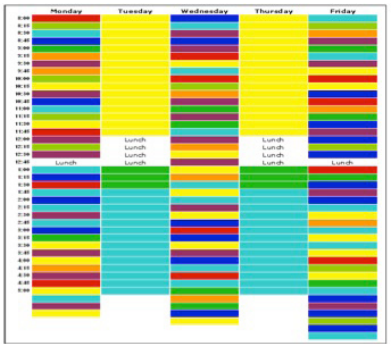
Donor site = ^
Pathology -
Closure - Skin - ^/0 Nylon - Interrupted
- Subcut - ^/0 Vicryl
Dressing - Primapore

Full Thickness Graft - ^/0 Silk Interrupted
Dressing - Bactigras / Allevyn over Skin Graft
ROS / Results ~ 7 Days

Notes to Reception:
Appointment: Dressing Clinic in ^ Days
Appointment: ROS Clinic in ^ Days
Billing: Bulk Bill
Claim: PROCESS
Discharge: Item No: 45451,312 ^ ,



An example of a normal GP appointment book (assortment of presenting complaints)



An example of a GP appointment book incorporating separate skin check and procedural sessions)

1. Skin checks / biopsies / non surgical / results
2. Procedures
3. Wound management

Setting Up Your Appointment Book

We encourage you to set up a regular weekly time to schedule your skin cancer patients. Most GPs will set aside the same half or whole day each week. This will provide you the time and resources to do your best work while providing the administration team of the clinic the clear place to schedule your appointments. This is important as, for every skin check you conduct and any lesion you find, the patient will inevitably be recalled whether it be weeks, months, or annually to see you again.

You'll also want to set up a structured time to conduct the procedures that will result from your skin checks and biopsies. Depending on the incidence in your community, you will have a number of procedures that result from the skin checks you conduct. Our advice is have a dedicated time that you can then work with the nurses in your practice to optimise. As your procedures aren't remunerated on a time basis, it pays to be efficient. If you could do one extra procedure in a session every week, you can imagine the multiplier effect this would have over a year on your and the practice's remuneration.

The second chart here shows an example of a GP doing two sessions a week of skin checks and two sessions of procedures.

Having a structured appointment book for skin checks and procedures will also help your support team of receptionists

and nurses to put the patients in the right place in your busy schedule. It also provides the added benefit that if your appointment for skin checks, for example, extends beyond a month you should consider adding a session as patients typically don't want to wait a great deal of time to find out if a suspicious lesion is actually a skin cancer. This way you can also monitor the size of your skin cancer practice.