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The No Surprises Act: What Do Plastic Surgeons Need to Know?

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Background: Out-of-network, or "surprise" bills, have grown common in recent years and have raised substantial concern for patients. Congress recently enacted the No Surprises Act, effective on January 1, 2022, ending the majority of out-of-network bills for privately insured patients. The aim of this review is to briefly summarize the history of surprise billing, describe the regulations of the No Surprises Act, and examine the impact this legislation will have on the field of plastic surgery.

Methods: A PubMed and Google Scholar literature search was conducted on out-of-network billing, or surprise bills, and the No Surprises Act. Media outlets, governmental agencies, and local and national medical organizations were additionally queried for surprise billing and the No Surprises Act.

Results: Under the No Surprises Act, privately insured patients are protected from surprise medical bills in emergency and nonemergency settings, and uninsured or self-pay patients must be provided a good faith estimate of service fees before receiving nonemergent care. Plastic surgeons may consent patients to receive out-of-network bills if consent is obtained at least 72 hours before rendering a nonemergency service. Despite these patient protections, this act may influence plastic surgeons' reimbursement rates and incentivize surgeons to alter their network status.

Conclusions: The No Surprises Act provides significant protections for patients. However, it may have adverse effects for plastic surgeons. Plastic surgeons will only get paid in-network fees while providing care to patients unless consent is properly obtained in a nonemergent setting. *(Plast Reconstr Surg Glob Open 2022;10:e4406; doi: 10.1097/GOX.0000000000004406; Published online 7 July 2022.)*

INTRODUCTION

Out-of-network billing, or "surprise" billing, occurs when a patient with private insurance is unknowingly administered care by an out-of-network provider at an in-network or out-of-network facility or emergency department (ED). These surprise bills have grown exceedingly common in recent years. For example, over 40% of ED visits led to out-of-network bills during 2017.[1] This high incidence of unanticipated medical charges has been a major point of concern for patients. Congress ultimately passed the No Surprises Act, which went into effect on January 1, 2022, to end the majority of out-of-network billing.

The No Surprises Act will protect the majority of insured patients from out-of-network bills and increase the transparency of healthcare costs. However, the impact the No Surprises Act will have on the field of plastic surgery is unclear. The purpose of this review is to (1) briefly summarize the history of surprise billing; (2) describe Congress's recent enactment of the No Surprises Act; and (3) examine the role this new federal legislation will have on the future of plastic surgery.

SURPRISE BILLING HISTORY

Surprise bills are frequently associated with air and ground ambulance transport, ED visits, and emergency surgery.[2–4] In these settings, patients are often unable to choose their providers, and thus are at risk for receiving out-of-network care, even at an in-network facility. Anesthesia, radiology, and emergency medicine physicians have been cited as some of the most frequent providers to bill patients surprise charges.[1,3,5] This is because many in-network hospitals contract out these services to out-of-network groups. For example, a study in 2012 demonstrated that up to 23.5% of emergency medicine physicians are independent contractors.[6] Following care by these providers, a patient's insurance may choose to cover anywhere from a portion to the entirety of the bill. However, out-of-network providers not paid in-full may

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charge the patient for the remaining balance, a surprise billing term known as balance billing. These balance bills may be substantial amounts, often over $1000, exposing patients to significant financial risks.[2] In a recent article by the *New York Times*, one patient from Florida received a bill for $6351 after requiring a rabies shot from a local ED, as his insurance only covered $12,006 of his care.[7] Costs of these emergency services vary by location. For example, in the aforementioned scenario, the adult rabies postexposure to prophylactic regimen can range from around $10,000 to upward of over $30,000, excluding associated ED fees.[7,8] However, since the Balanced Budget Act of 1997, all patients with public health insurance plans, such as Medicare or Medicaid, are prohibited from receiving surprise bills in any form. Thus, the population receiving these surprise and balance bills are patients under the age of 65 enrolled in private health insurance plans.

As the incidence of surprise bills has continued to grow in recent years,[1] several states have enacted laws to address surprise billing. Two commonly utilized legislative approaches involve benchmark payments and arbitration. The benchmark payment system involves setting an upper limit for out-of-network provider payments. This approach has been previously implemented by California in 2017.[9] Conversely, other states, including New Jersey and New York, adopted an arbitration process to address surprise bills. In these states, if providers and insurers cannot agree upon a set payment, they may both submit a proposed payment to a third-party entity, or an arbitrator, who subsequently chooses between the two offers. These arbitrators serve as independent mediators who may be designated and approved by the state government. Although these state laws have provided patients with some degree of protection from surprise medical bills, they are not comprehensive and do not cover employer-funded health plans, necessitating the need for federal legislation. There has been much controversy over whether federal legislation should adopt arbitration or a benchmark payment system to address surprise bills. Advocates of the benchmark payment approach have argued that the arbitration system would be expensive and ambiguous, as well as inflate healthcare expenses.[10] Conversely, those who support arbitration contend that benchmark payments would give insurers the ability to solely dictate payments, undermining the provider-insurer negotiation process.[11]

THE NO SURPRISES ACT

In light of the rising incidence of surprise billing, Congress passed the No Surprises Act in December 2020.[12] This law impacts privately insured patients in both emergency and nonemergency settings, as well as self-pay or uninsured patients in nonemergency settings. Public insurance programs, such as Medicaid and Medicare, have existing protections against surprise bills, so these plans are not included in the No Surprises Act. Effective since January 1, 2022, any privately insured patient who receives emergency care from out-of-network providers can only be charged the in-network cost-sharing amount. This means patients are only responsible for paying for a service's in-network copayment, coinsurance, deductible, and/or out-of-pocket maximum, regardless of the provider's network status. This extends to include air-ambulance transport and postemergency stabilizing care but does not include ground ambulance transport. Ground ambulance transport is not included under the protections of the No Surprises Act due to the complex operating practices surrounding this mode of emergency transport. Unlike air-ambulance transport, ground ambulances are frequently regulated by local agencies, including fire departments, or state government agencies, making federal regulation of surprise billing in this context difficult.[13] Postemergency stabilization care is protected from surprise bills under the No Surprises Act until the provider deems the patient can utilize nonmedical transport to safely move to an in-network facility, and the patient must be able to provide consent to this transfer. Additionally, insured patients may not receive out-of-network charges for any ancillary care at any time and may not be consented for this care, regardless of emergent or nonemergent settings. This includes any service related to pathologists, neonatologists, anesthesiologists, radiologists, emergency medicine, hospitalists, assistant surgeons, or diagnostic testing. Regarding privately insured patients in nonemergent settings, including ambulatory surgical centers, patients are further protected from out-of-network bills, unless they consent to care from an out-of-network provider at an in-network facility and thus waive federal protections. Patients must provide voluntary written consent to the out-of-network care and costs at least 3 days before the service. For uninsured or self-pay patients in nonemergent settings, providers are mandated under the No Surprises Act to provide a good faith estimate of the total costs within 1–3 business days of scheduling the service.

The No Surprises Act involves a binding arbitration or independent dispute resolution process as opposed to a benchmark payment system for privately insured patients.[14] As such, it removes these patients from the insurer-provider dispute process, and they will not be held responsible for any fees associated with this process. After the patients' initial in-network payment, insurers and out-of-network providers will have approximately 30 days to negotiate and agree upon a payment. If the two

Takeaways

Question: How will the No Surprises Act impact plastic surgeons?

Findings: Under the No Surprises Act, insured patients are protected from unexpected bills when receiving emergency and nonemergency care. Uninsured or self-pay patients must be provided good faith estimates of service costs. Plastic surgeons will get paid in-network fees while providing care to patients unless consent is properly obtained in a nonemergent setting.

Meaning: The No Surprises Act protects patients from excessive charges and improves transparency of healthcare costs; however, this legislation may have adverse effects for the field of plastic surgery.

parties are unable to reach a common ground, they have 4 days to initiate the binding arbitration process, and they must each submit an administrative fee of $50. Each party must then submit an offer within 10 days. The arbitrator must be selected from a list of certified organizations that partake in the independent dispute resolution process which may be found through the Centers for Medicare and Medicaid resources. The arbitrator's services are estimated by the Department of Health and Human Services (HHS) to cost $400 on average,[15] a fee that must be paid for by the losing party in this independent dispute resolution process. The selected arbitrator is instructed to take several factors into consideration, including the insurer's median in-network rates or "qualifying payment amount," complexity of the case, provider's clinical experience, and previous contracted rates. It is important to note, the qualifying payment amount is deemed to be a crucial aspect considered by the arbitrator. The arbitrator then chooses one of the two parties' proposed payments, and they may not select another amount. The losing party is responsible for paying the fees associated with the arbitration process. Additionally, either party must wait 90 days after the decision is made before they can initiate the process again for similar services (Fig. 1). As such, Congress hopes to ensure a fair payment process and discourage parties from proposing extreme payments, as well as promote negotiations between insurers and providers over pursuing arbitration.

A similar resolution process is conducted for uninsured or self-pay patients under the No Surprises Act. If an uninsured or self-pay patient receives a medical bill greater than the provider's good faith estimate by at least $400, the patient may initiate a patient–provider dispute resolution process through an online federal portal within 120 days of receiving the bill. Upon initiation, the patient is required to pay a $25 administrative fee. A third-party certified dispute resolution entity, or arbitrator, will be selected through HHS and will contact the provider. The provider then has 10 days to upload pertinent documents. Throughout this process, the patient and provider may negotiate a payment. If the two parties reach an agreement, the provider must notify the arbitrator within 3 days. However, if unable to reach common ground, the selected arbitrator will determine the amount the patient will pay for the services within 30 days. Arbitrator fees associated with the patient–provider dispute resolution process are not discussed by HHS.[16]

Enforcement of the No Surprises Act primarily lies at the state level; however, compliance may additionally be assessed at a federal level through the Center for Medicare

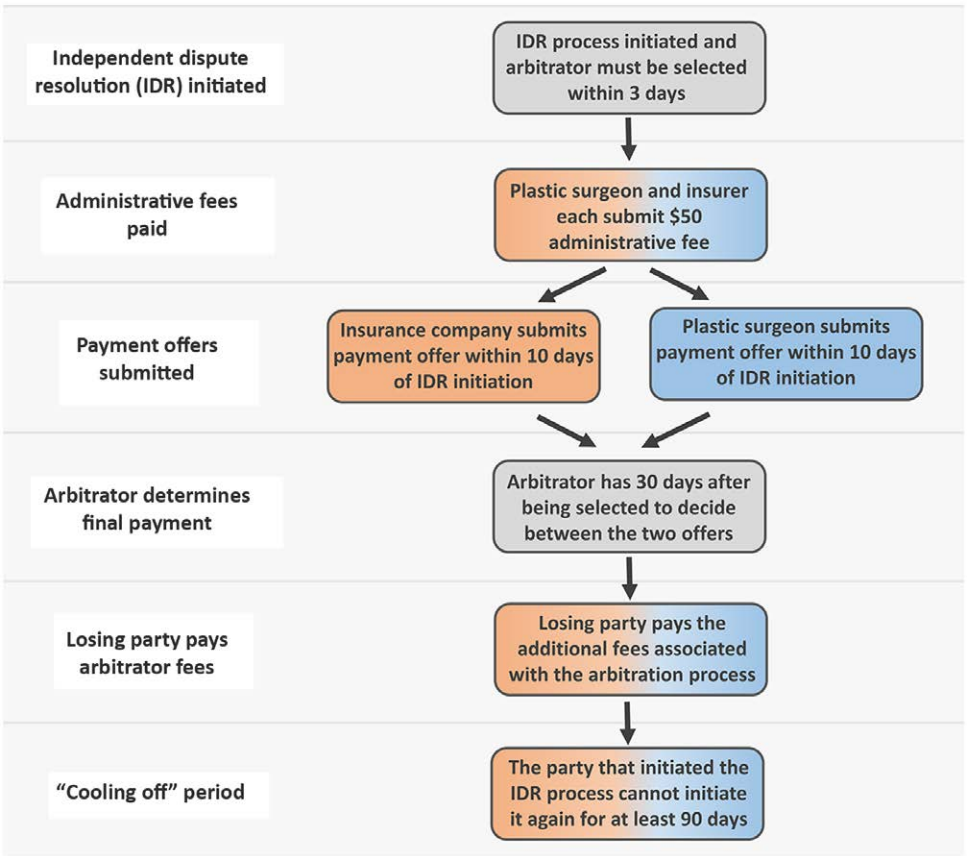

Fig. 1. Steps involved in the independent resolution process. Gray identifies the arbitrator, orange represents the insurer's actions, and blue represents the actions of the plastic surgeon.

and Medicaid Services (CMS). Providers who violate the provisions of the No Surprises Act are subject to civil monetary penalties. For each violation, penalties can be up to $10,000 and are determined by CMS through consideration of several factors, including the severity of the violation and history of the providers' prior violations.

THE NO SURPRISES ACT IN PLASTIC AND RECONSTRUCTIVE SURGERY

Plastic surgeons have been previously implicated in surprise billing. In patients receiving emergency care from a plastic surgeon in the ED, researchers have demonstrated that 40% of these visits may lead to a surprise bill.[1] This high incidence is likely due to multiple factors, such as the large number of emergency plastic surgery procedures (ie, laceration repair), utilization of air and ground ambulance transport for trauma patients, and the overall interdisciplinary quality of plastic surgery care.[3] Many plastic surgeons also elect to not participate in health plans and do not accept insurance. In all these scenarios, patients are at the high risk of unknowingly receiving an out-of-network service or receiving care from an out-of-network plastic surgeon or ancillary provider.

Privately Insured Patients

The No Surprises Act prohibits out-of-network plastic surgeons from surprise billing patients when providing emergency care. Following ED stabilization, a patient may be admitted to the hospital and may require a delayed operation by an out-of-network plastic surgeon (ie, tendon injury repair). This care will remain protected against surprise bills, unless the out-of-network plastic surgeon believes the patient may be safely transferred to another facility with an in-network plastic surgeon, and the patient provides written consent. Additionally, during emergency or post-stabilization care, patients may still receive ancillary services from an out-of-network provider, even if both the plastic surgeon and the facility are in-network. For example, it is common for out-of-network anesthesiologists to provide anesthetic care in operative emergency settings.[17] Furthermore, during operations performed by in-network plastic surgeons in emergency settings, complications may be an unavoidable outcome. Surgical colleagues, those of whom can be out-of-network, may be requested to assist in addressing complications. In these settings, insured patients are protected against out-of-network bills at in-network facilities, regardless of any providers' network status. These clinical scenarios are further depicted in Figures 2 and 3.

In nonemergency settings, including in-network ambulatory surgical centers and private practice clinics, patients may not be billed out-of-network charges for any ancillary services, such as additional care provided by surgical assistants, anesthesiologists, pathologists, or radiologists. For example, if a breast-reconstruction patient undergoes additional revision surgery at an outpatient surgical center, and the anesthesiologist is out-of-network, they will only be charged the in-network amount. Furthermore, if any complications were to arise and necessitate treatment from an out-of-network provider, these patients likewise will only pay the in-network costs. If a patient desires to

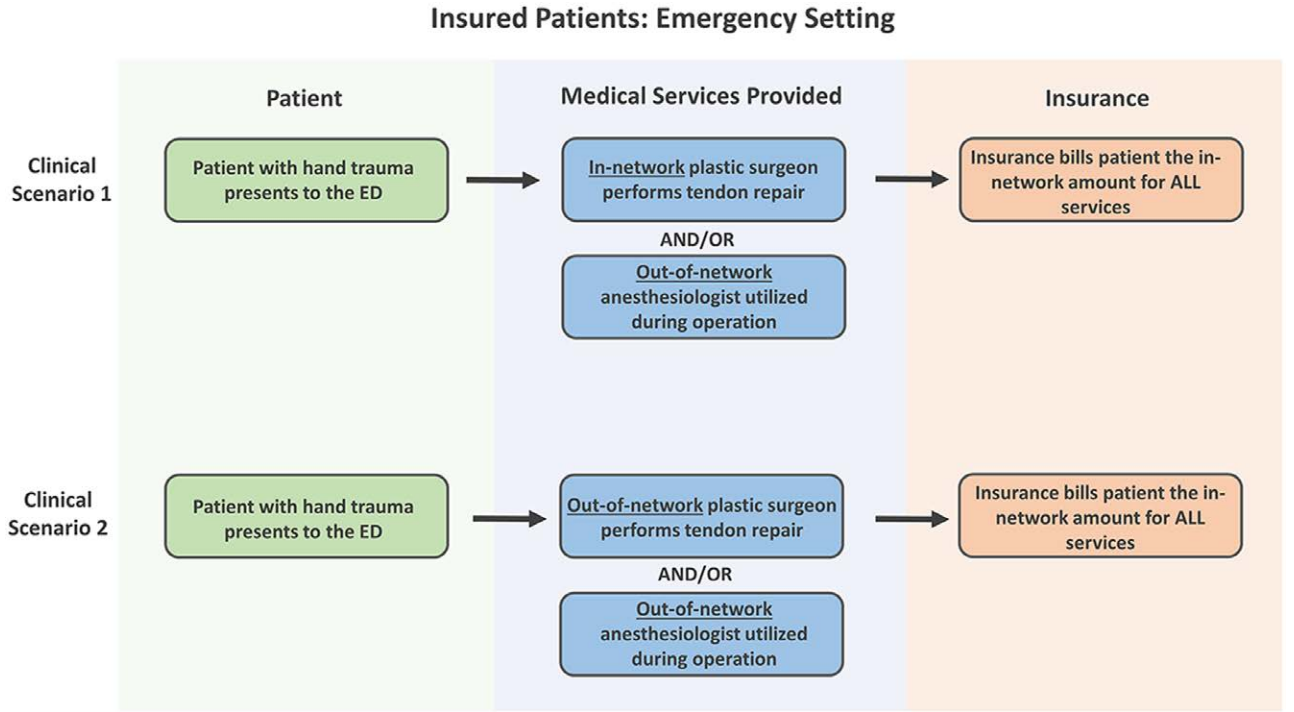

Fig. 2. Two clinical scenarios of a privately insured patient receiving emergency plastic surgery care under the No Surprises Act. Regardless of the network status of the plastic surgeon and/or anesthesiologist, patients will only be charged the in-network amount for all rendered emergency services.

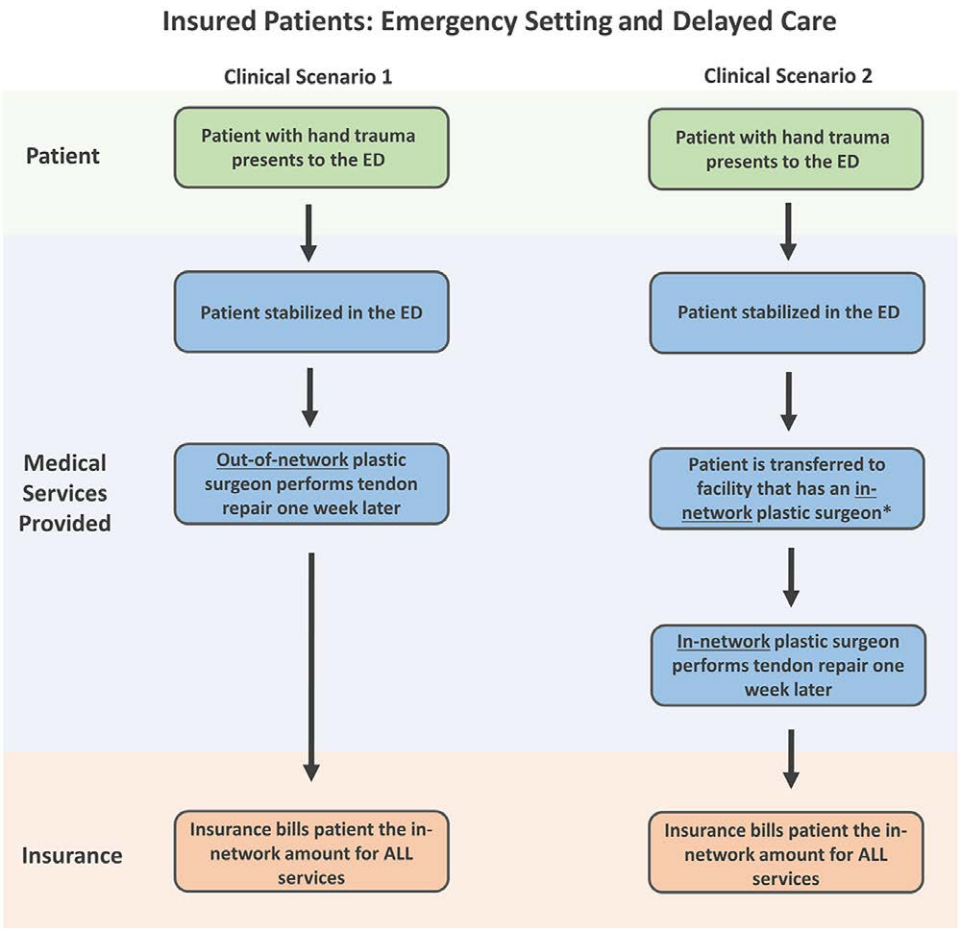

Fig. 3. Two clinical scenarios are depicted of a privately insured patient receiving delayed emergency plastic surgery care under the No Surprises Act. Emergent plastic care may be delayed and provided by an out-of-network surgeon; however, a patient is only responsible for the in-network service costs. This also remains the case if a patient is transferred to another facility for plastic surgery care. *The plastic surgeon must deem the patient can safely be transferred, and the patient must consent to this transfer.

receive care by a specific out-of-network plastic surgeon, the patient must provide written consent to receive out-of-network charges at least 72 hours before the service is rendered. However, under the No Surprises Act, patients cannot be consented for any out-of-network care performed by an ancillary provider, regardless of the setting, effectively ending all out-of-network bills for ancillary care within plastic surgery. For instance, even if a patient provides consent for an operation by an out-of-network plastic surgeon, any care administered by an out-of-network ancillary provider will always be billed the in-network cost-sharing amount. Figure 4 depicts a clinical scenario of an insured patient receiving nonemergent plastic surgery care in the context of the No Surprises Act.

In emergency settings, or nonemergency settings, in which a patient has not consented to out-of-network care, the patient will subsequently receive a bill for the in-network amount of the service. If the plastic surgeon who provided care is out-of-network, they will initiate the independent dispute resolution process with the patient's insurance company. The insurer will make an initial out-of-network payment to the plastic surgeon or submit a denial. The insurer and plastic surgeon will have 30 days to negotiate the amount the plastic surgeon should be paid for their services. If the parties do not reach an agreement, the plastic surgeon or the insurer may initiate the independent dispute resolution process in which the arbitrator will select between the two offers.

Uninsured or Self-pay Patients

Patients are often financially responsible for cosmetic plastic surgery procedures.[18] If patients are determined to be uninsured or self-pay for a plastic surgery operation, under the No Surprises Act, plastic surgeons are mandated to provide a good faith estimate of the total costs before the service. Plastic surgeons must provide this estimate at the patient's request, within one business day of the service being scheduled if it is at least three business days before the operation, or within 3 business days of the service being scheduled if it is at least 10 days before the operation. It is crucial to include all necessary information within the estimate, in the patient's language. This includes patient information, the services to be provided, diagnostic codes, the providers and facilities, and any

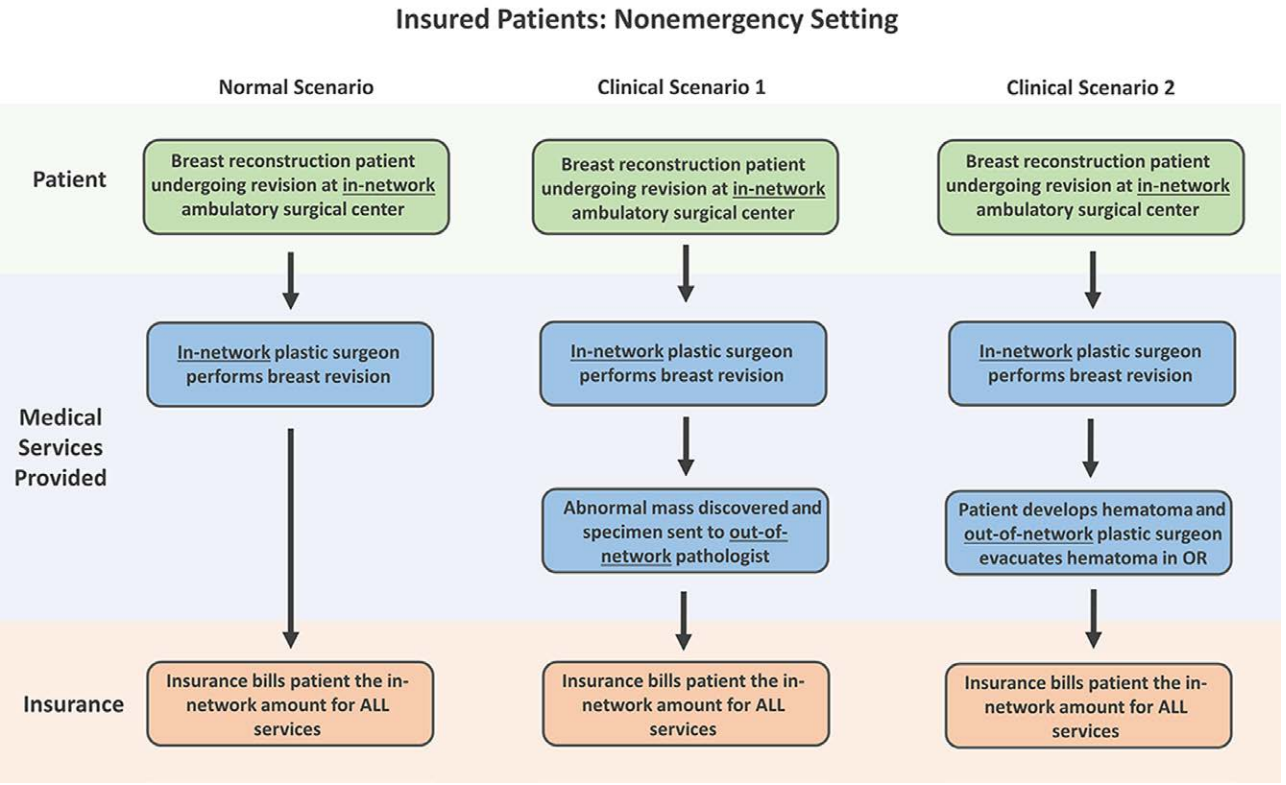

Fig. 4. Two clinical scenarios of a privately insured patient receiving nonemergent plastic surgery care under the No Surprises Act. Patients may not be charged surprise bills for out-of-network care provided by ancillary providers (ie, pathologists) or out-of-network care provided to address postoperative complications.

disclaimers. Instructions and a template for the good faith estimate may be implemented in plastic surgery procedures and obtained from the CMS website.[19] If the plastic surgeon bills the patient for a substantially higher amount (>$400), the patient may initiate the patient–provider dispute resolution, or arbitration, process through the online federal portal within 120 days of the bill. The arbitrator will contact the plastic surgeon to upload the good faith estimate, the patient's bill, and any documentation for reasoning behind the bill discrepancy. If the arbitrator approves this process, they will decide on the patient's payment within 30 days. Figure 5 further details this process and associated timeline with a clinical example.

Future Implications

The No Surprises Act will substantially reduce consumer and patient costs. However, it may be unfavorable for plastics surgeons. Several provider groups have already filed lawsuits against HHS regarding the No Surprises Act, including the American Medical Association, claiming opposition due to unfair insurer advantages.[20] Under the No Surprises Act, commercial health insurance companies determine the median in-network rate, or qualifying payment amount, in the provider-insurer independent dispute resolution process. This qualifying payment amount is central to the arbitrators' decision-making process when determining provider reimbursement. These insurance groups may be less inclined to negotiate higher qualifying payment amounts for services, resulting in low in-network rates for plastic surgeons and diminished reimbursement. Consequently, plastic surgeons may have to accept lower in-network rates for their services or otherwise face contract termination with insurers. Plastic surgeons may conversely choose to venture out-of-network due to diminished reimbursement for their services, resulting in less in-network plastic surgeons and impeding equitable patient access to plastic surgery care, as well as impacting physician consolidation and increasing healthcare costs.

Plastic surgeons may further be incentivized to work out-of-network as a result of the aforementioned independent dispute resolution process, as winning these arbitration disputes may lead to increased rates of reimbursement for plastic surgeons compared to in-network service rates. A similar antisurprise billing legislation was enacted in New York and led to patients saving four million dollars over a 3-year time span.[21] The majority of the arbitration disputes over emergency services during these 3 years were most commonly attributed to plastic surgeons (40%).[21] On the other hand, the independent resolution process can be expensive and cumbersome, necessitating additional administrative fees. This may encourage plastic surgeons to instead reduce the rates of their services to avoid this tedious process. As time progresses, further examination of the No Surprises Act within plastic surgery will be necessary to better assess

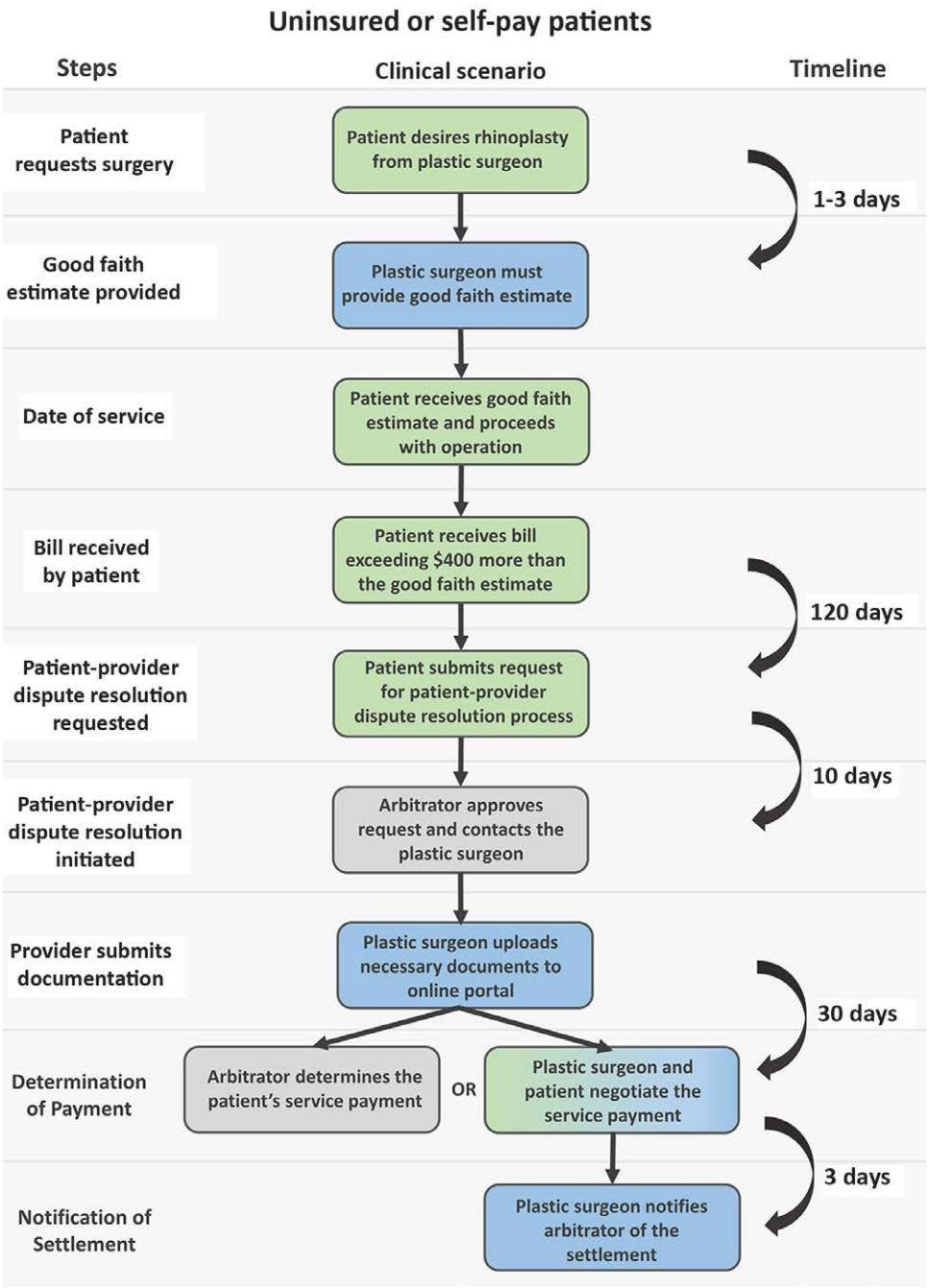

Fig. 5. Shown is a clinical scenario of an uninsured or self-pay patient receiving nonemergent care under the No Surprises Act. On the left, the steps of the patient–provider dispute process are listed. On the right is the timeline associated with these steps. Green represents the actions of the patient. Blue represents the actions of the plastic surgeon. Gray represents the actions of the arbitrator.

how this act impacts surgeon reimbursement and network status.

Regarding uninsured or self-pay patients, who comprise a substantial proportion of plastic surgery care,[18,22–24] plastic surgeons must remain aware of the rules mandated by the No Surprises Act. Costs of plastic surgery services should be cataloged in advance such that surgeons may promptly provide patients with good faith estimates when necessary. As costs of plastic surgery procedures have continued to rise in recent years,[25,26] plastic surgeons will need to maintain transparency regarding these estimates within the changing healthcare ecosystem. Furthermore, plastic surgeons should maintain accuracy in approximating total fees to avoid the patient–provider dispute process when possible, as this may be time consuming and costly.

CONCLUSIONS

The No Surprises Act protects patients from excessive charges and improves transparency of healthcare costs. Insured patients will be protected from unexpected bills when receiving emergency and nonemergency care, while uninsured or self-pay patients will be provided good faith estimates of service costs. Plastic surgeons will only get paid in-network fees while providing care to patients unless consent is properly obtained in a nonemergent setting.

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REFERENCES

1. Sun EC, Mello MM, Moshfegh J, et al. Assessment of out-of-network billing for privately insured patients receiving care in in-network hospitals. *JAMA Intern Med*. 2019;179:1543–1550.
2. Chhabra KR, Fuse Brown E, Ryan AM. No more surprises—new legislation on out-of-network billing. *N Engl J Med*. 2021;384:1381–1383.
3. Dekhne MS, Nuliyalu U, Schoenfeld AJ, et al. "Surprise" out-of-network billing in orthopedic surgery: charges from surprising sources. *Ann Surg*. 2020;271:e116–e118.
4. Duffy EL, Adler L, Ginsburg PB, et al. Prevalence and characteristics of surprise out-of-network bills from professionals in ambulatory surgery centers. *Health Aff (Millwood)*. 2020;39:783–790.
5. Cooper Z, Nguyen H, Shekita N, et al. Out-of-network billing and negotiated payments for hospital-based physicians. *Health Aff (Millwood)*. 2020;39:24–32.
6. Kane CK, Emmons DW. New data on physician practice arrangements: private practice remains strong despite shifts toward hospital employment. American Medical Association. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf. Accessed February 2, 2022.
7. Kliff S, Katz J. Hospitals and insurers didn't want you to see these prices. Here's why. *The New York Times*. Available at https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html. Accessed February 13, 2022.
8. Appleby J. Meow-ch! The $48,512 Cat Bite. *Kaiser Health News*. Available at https://khn.org/news/biologist-faces-48512-bill-for-rabies-shot-after-cat-bite/. Accessed February 13, 2022.
9. Health Care Coverage: Out-of-network Coverage, AB 72 (2016). Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72
10. Bernstein J. Not the last word: surprise medical bills are hardly charitable. *Clin Orthop Relat Res*. 2020;478:2213–2217.
11. Fuse Brown EC. Stalled federal efforts to end surprise billing—the role of private equity. *N Engl J Med*. 2020;382:1189–1191.
12. No Surprises Act, HR 3630, 116th Congress, 1st sess (2019). Available at https://www.congress.gov/bill/116th-congress/house-bill/3630. Accessed February 13, 2022.
13. Kliff S, Sanger-Katz M. Why surprise-bills ban omits ambulances. *The New York Times*. 5-5. Available at https://www.nytimes.com/2020/12/22/upshot/ground-ambulances-left-off-surprise-medical-bill-law.html. Accessed February 2, 2022.
14. American Medical Association. Guide to surprise billing provisions in the Consolidated Appropriations Act 2021. American Medical Association. Available at https://www.ama-assn.org/system/files/2021-02/surprise-billing-provisions-guide.pdf. Accessed February 2, 2022.
15. Centers for Medicare and Medicaid Services. Calendar year 2022 fee guidance for the federal independent dispute resolution process under the No Surprises Act. Centers for Medicare and Medicaid Services. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf. Accessed April 4, 2022.
16. Department of Health and Human Services. Patient-provider dispute resolution (PPDR) administrative fee as established in surprise billing, part II; interim final rule with comment period. Department of Health and Human Services. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Patient-Provider-Dispute-Resolution-Administrative-Fee-CMS-9908-IFC.pdf. Accessed April 4, 2022.
17. Chhabra KR, Sheetz KH, Nuliyalu U, et al. Out-of-network bills for privately insured patients undergoing elective surgery with in-network primary surgeons and facilities. *JAMA*. 2020;323:538–547.
18. Hansen DG, Abbott LE, Johnson RM, et al. Variation in hospital-based acute care within 30 days of outpatient plastic surgery. *Plast Reconstr Surg*. 2014;134:370e–378e.
19. Centers for Medicare and Medicaid Services. Standard form: "Good Faith Estimate for Health Care Items and Services" under the no surprises act. Available at https://www.apaservices.org/practice/legal/managed/good-faith-estimate-template.pdf. Accessed February 2, 2022.
20. American Medical Association. AMA and AHA file lawsuit over No Surprises Act final rule. American Medical Association; 2021. Available at https://www.ama-assn.org/press-center/press-releases/ama-and-aha-file-lawsuit-over-no-surprises-act-final-rule. Accessed February 2, 2022.
21. Lacewell LA. New York's Surprise Out-of-Network Protection Law: Report on the Independent Dispute Resolution Process. New York: New York State Department of Financial Services; 2019:1–30. Available at https://www.nber.org/papers/w23623. Accessed February 1, 2022.
22. Shermak MA, Choo S, Mallalieu J, et al. Financial analysis of factors impacting reimbursement for abdominoplasty. *Obes Surg*. 2009;19:1236–1239.
23. Chen JT, Nayar HS, Rao VK. 10 Years later: lessons learned from an academic multidisciplinary cosmetic center. *Plast Reconstr Surg Glob Open*. 2017;5:e1459.
24. Chattha A, Bucknor A, Chi D, et al. Drivers of hospital costs in the self-pay facelift (rhytidectomy) patient: analysis of hospital resource utilization in 1890 patients. *Aesthetic Plast Surg*. 2018;42:603–609.
25. American Society of Plastic Surgeons. 2018 Plastic surgery statistics report. American Society of Plastic Surgeons. 2018:1–25. Available at https://www.plasticsurgery.org/documents/News/Statistics/2018/plastic-surgery-statistics-full-report-2018.pdf. Accessed February 1, 2022.
26. American Society of Plastic Surgeons. 2020 Plastic surgery statistics report. American Society of Plastic Surgeons. 2020:1–26. Available at https://www.plasticsurgery.org/documents/News/Statistics/2020/plastic-surgery-statistics-full-report-2020.pdf. Accessed February 1, 2022.