

Downstream Impact for Plastic Surgeons in the United States from the “No Surprises Act”

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Background: The No Surprises Act, signed into the US federal law in 2020, establishes a floor for reimbursement determined by insurance payors for out-of-network charges rendered by providers in emergency services. Physicians are not permitted to balance bill patients for the difference. An arbitration process is outlined for mediation between provider and payor if needed.

Methods: Policy analysis demonstrates many plastic surgeons utilize a revenue stream including both fee-for-service cosmetic work and insurance-covered reconstructive intervention. For Maintenance of Certification from the American Board of Plastic Surgery and/or membership to the American Society of Plastic Surgeons, plastic surgeons must operate only in accredited facilities, which in turn require that similar privileges are held in a hospital.

Results: Given rapidly developing economic pressures, hospitals no longer remain neutral sites for surgical privileging as they seek strategies to mitigate financial loss by directly competing for patients. A downstream consequence of the requirement for hospital privileging is that plastic surgeons are forced to manage increasing on-call responsibilities despite shrinking reimbursement. Plastic surgeons whose board certification was the first to be time-limited are now reaching the stage of practice where they may transition exclusively to out-patient services.

Conclusions: Plastic surgeons in independent solo or small group practices are rendered vulnerable since they may not be able to find coverage of in-patient responsibilities at lower reimbursement rates. Rather than allowing loss of board certification in this population, rational alternatives on an organizational level are proposed for keeping the process equitable as plastic surgeons progress along the practice pathway. (*Plast Reconstr Surg Glob Open* 2022;10:e4202; doi: 10.1097/GOX.0000000000004202; Published online 18 March 2022.)

INTRODUCTION

There has been little published evaluation of the downstream consequences from the No Surprises Act for plastic surgeon stakeholders. This act, signed into federal United States law on December 27, 2020, by President Trump, is part of the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB—Private Health Insurance and Public Health Provisions). The No Surprises Act addresses surprise medical billing. The criteria of a surprise medical bill are met when a patient receives a balance from a treating out-of-network (OON) physician after charges are

processed by insurance. This balance represents the difference between what insurance paid and what the OON physician charged for services performed while a patient was treated at an in-network facility. This act broadly tasks the Departments of Health and Human Services, Treasury, and Labor with implementation; much of which commences January 1, 2022. More recently, on September 30, 2021, a second interim final rule was issued providing further protections for patients.^{1,2} Meanwhile, many states have additional regulations at the local level regarding processes limiting OON balance billing.

The overall structure of the act establishes a federally mandated floor for emergency care reimbursement rendered by OON physicians. The No Surprises Act permits OON balance billing of patients *only* if non-emergent care is rendered while the patient provides consent

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Disclosure: Dr. Canady served as the 2009 President of the American Society of Plastic Surgeons. His medical career was spent in academic medicine as an in-network physician. As a result of subsequent employment at Johnson & Johnson, he has stock and options. D. Zbar is employed by a for-profit healthcare system. Dr. R.I.S. Zbar remains in private solo practice and has been in-network throughout his career.

and is provided a good-faith estimation of the cost while instructions are provided on how to obtain in-network coverage. Essentially, this scenario is satisfied only when a patient electively presents for a medically necessary but non-urgent procedure as an out-patient. On the other hand, any patient seen for consultation in the emergency department or as an in-patient is blanketed by the law. Whether an urgent care center falls under this rubric is still being evaluated.³ Regardless, direct OON billing of the patient after insurance processing of charges is forbidden in emergent situations. OON plastic surgeons who bill insurance will be required to accept in-network rates from the insurance plans as a starting point based on this legislation. If there is disagreement about the reimbursement allowed, then arbitration is pursued directly with the insurance company as outlined by the act. No longer can patients be held responsible for differences between what insurance recognizes as reasonable versus what the physician bills.

HOW THE NO SURPRISES ACT NEGATIVELY IMPACTS PLASTIC SURGEON REVENUE STREAMS

The diversity of revenue streams in plastic surgery differs from other surgical specialties in that cosmetic procedures generate income in a fee-for-service fashion, whereas reconstructive work is generally managed through insurance either in-network or OON. The breadth of work is the source of pride for many plastic surgeons. Cosmetic procedures can be as straightforward as injectables or as high-risk as postbariatric body contouring. The same is true for reconstructive endeavors: from lumps/bumps to free flaps. The revenue model of many plastic surgery practices relies on the surgeon remaining OON with commercial insurance while covering the emergency department or hospital in-patient for trauma or chronic wounds. This model works well for providers whereby surgeons build an aesthetic practice and reputation while generating revenue that they consider reasonable and customary from emergency reconstructive consultations that are commercially insured. This revenue cycle proves so robust that many plastic surgeons continue this financial structure well along their practice journey. The American Society of Plastic Surgeons (ASPS) lobbied Congress to mitigate negative sequelae of this act, recognizing the fact that many members were OON.⁴

Unfortunately, for those plastic surgeons subscribing to the OON model to generate a strong revenue stream, its continued feasibility is threatened by the downstream requirement of both the ASPS and the American Board of Plastic Surgery (ABPS) that members hold procedural privileges only in accredited facilities.^{5,6} Although this requirement is exquisitely logical from a patient safety viewpoint and certainly not unique among boards belonging to the American Board of Medical Specialties (ABMS), it becomes problematic in this evolving economic environment of competing healthcare systems. The safety of free-standing or office-based ambulatory surgery is well established.^{7,8} Advantages of these facilities

Takeaways

Question: What are the downstream consequences of the No Surprises Act for plastic surgeons?

Findings: Policy evaluation shows (1) revenue stream of out-of-network plastic surgeons will be negatively impacted and (2) fewer plastic surgeons will be available for hospital coverage. Hospitals are aggressively seeking to mitigate financial losses. Due to the requirements of hospital privileging for board certification, plastic surgeons may find themselves facing increased on-call demands.

Meaning: Alternatives should be offered to plastic surgeons obviating the need to hold hospital privileges as a quality metric since hospitals are not neutral bodies.

over hospital-based out-patient surgery includes cost-containment, convenience, and efficiency.⁹ However, for a facility such as a surgical center or private surgical suite to be considered appropriately certified, the participating surgeon must simultaneously possess similar privileges at a local, accredited hospital among other requirements. If plastic surgeons must continue to hold similar privileges at a local hospital, it consequently means that those plastic surgeons who are OON are now at risk to provide on-call coverage in emergencies at rates established by payors. This is an unintended consequence with significant downstream repercussions.

The problem specifically arises along the revenue stream in that those surgeons who previously leveraged OON fees while being on-call for a hospital can no longer do so with the No Surprises Act. Although plastic surgeons may believe they are not required to attend to simple lacerations in the emergency department or infected pressure sores in the intensive care unit, since members of other specialties possess overlapping privileges which can intervene, the facts speak otherwise. The decision to request an on-call specialist consultation—thus activating the federally enacted Emergency Medical Treatment and Labor Act (EMTALA)—resides with the person (physician, registered nurse, or physician assistant/associate) requesting the consult based on his or her examination of a patient and not the consultant responding. Therefore, depending on the specific policies of the hospital, on-call plastic surgeons are indeed at risk for mandated attendance.¹⁰ Therefore, a plastic surgeon who refuses a hospital-based consult when on-call runs the risk of disciplinary review by a hospital and consequently a state medical board inquiry if he or she refuses to attend.

CURRENT RESPONSE OF HOSPITALS TO THE ECONOMIC CLIMATE

Hospitals are rapidly merging into expansive healthcare system conglomerates to better compete for high-margin procedures. As unified entities covering large geographic regions, these healthcare systems are better positioned to leverage favorable reimbursement from payors. However, the existence of free-standing surgical facilities offering patients convenient, lower cost care directly

threatens hospitals by facilitating out-migration of patients. Furthermore, payors are exacerbating patient leakage from healthcare systems by designing payment incentives encouraging less in-patient/out-patient hospital management in favor of lower cost, free-standing ambulatory treatment. As a direct reaction to survive these revolutionary changes, hospital systems are purposely maneuvering to consolidate the provider market, thereby redirecting volume back into their facilities and thus battling this economic strategy of the payors. These relationships are depicted in a causal loop diagram (Fig. 1). Although quality of care remains a critical mission focus for everyone, increasingly it is observed that economic variables factor into staffing decisions and appointments. Mission creep occurs as healthcare systems pay disproportionate attention to generating and sustaining profit. Arguably, hospitals are no longer neutral in who specifically joins the medical staff and what responsibilities are required to maintain membership. Providers who perform lucrative procedures are actively courted and provided additional benefits over those providers whose procedures do not. Indeed, some forms of economic credentialing are legally practiced by healthcare systems.¹¹ Expanding employed multispecialty groups and directing the care rendered provides a definite competitive advantage to hospitals over supporting those in independent solo or smaller group practices. Obviously, discriminatory practices based on race, sex, or religion are not tolerated.

It behooves plastic surgeons to be aware that some but not all hospitals could have an opt out of on-call coverage outlined in the medical staff by-laws of the facility. This clause usually applies after a certain age is attained or after a specified number of years of service have been rendered. Plastic surgeons on staff at hospitals lacking this type of clause in the by-laws may have mandated on-call coverage. This will be further exacerbated because those hospitals requiring on-call coverage will find themselves

further short of plastic surgeons as individuals change membership to those facilities which do not mandate on-call coverage as OON reimbursement shrinks. This is a negative reinforcing loop with an undesired outcome: there will be fewer plastic surgeons attending emergency on-call in hospitals that mandate coverage (Fig. 2). On the other hand, those hospitals with an exclusionary clause based on service years or that have a plethora of plastic surgeons on staff will find themselves inundated with more applications for membership, thus completely changing the practice referral environment. In fact, some hospitals concerned about protecting catchment areas have already closed ranks and refused additional medical staff membership in those fields that they consider over-represented to stabilize referral bases. This leaves some plastic surgeons who wish to maintain Board Certification and/or membership to ASPS without any options but for staff membership in hospitals requiring on-call coverage.

POTENTIAL RESPONSE OF PLASTIC SURGEONS TO THE ECONOMIC CLIMATE

Accordingly, plastic surgeons may choose to direct volume to one-room surgical suites with appropriate monitoring using only local anesthesia to avoid hospital on-call obligations. Anecdotally, many specialties such as dermatology, ophthalmology, and otolaryngology have done similarly. A broad variety of plastic surgical procedures previously thought to require sedating anesthesia are now commonly performed wide awake with variations of tumescent technique and ultrasound-guided blocks.¹² The standard of care permits liposuction, abdominoplasty, breast augmentation, rhytidectomy, and hand surgery to be easily performed without sedating anesthesia in a one-room surgical suite with appropriate monitoring.¹³⁻¹⁶ Management of even complex skin cancers for both extirpation and reconstruction is generally accomplished

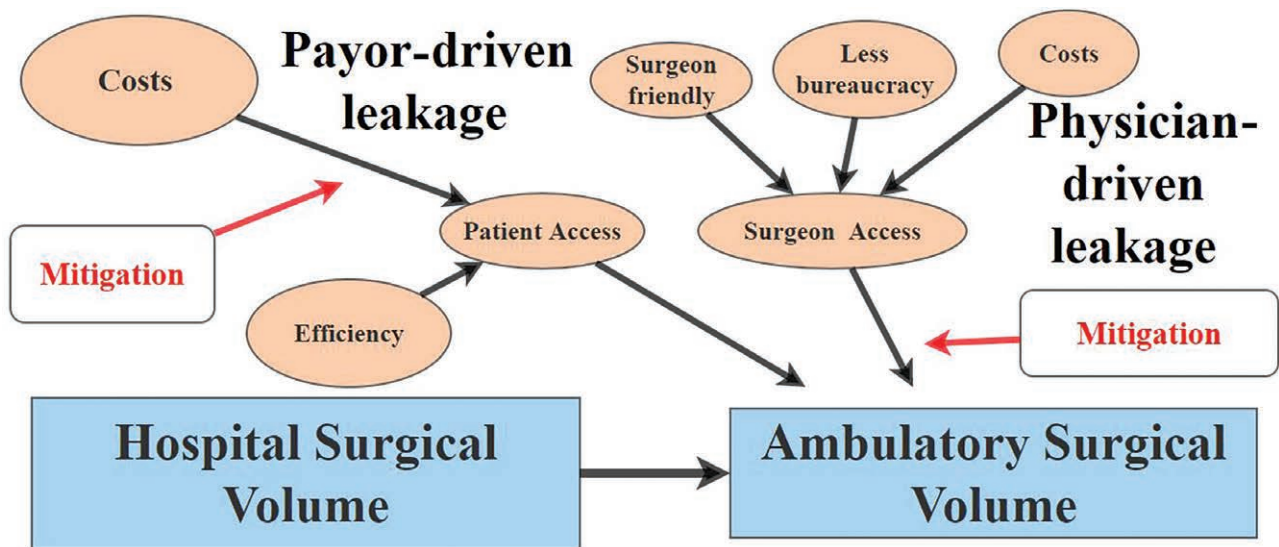


Fig. 1. Causal loop diagram of the balancing variables influencing the direction of surgical volume to the hospital versus free-standing surgical centers. Red arrows indicate strategies employed by hospitals to decrease patient loss to competing ambulatory centers.

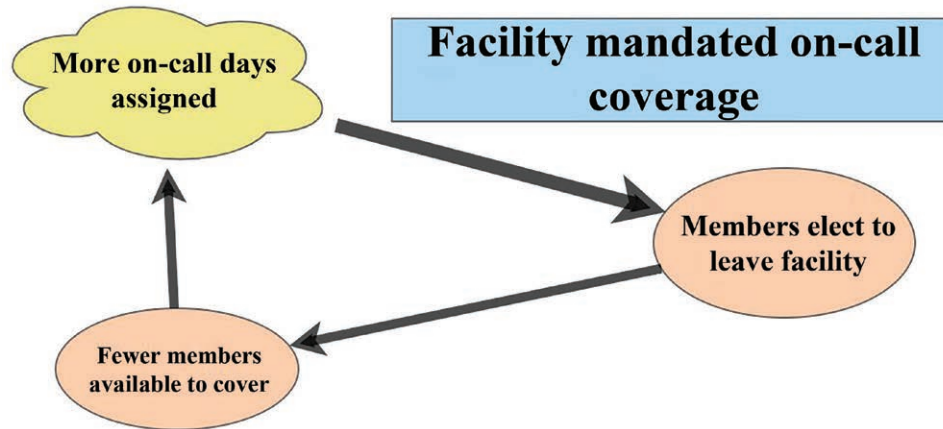


Fig. 2. Negative reinforcing causal loop diagram illustrating the impact of facility mandated on-call coverage for surgeons in vulnerable solo or small group independent practices.

under local anesthesia.¹⁷ However, a distinction must be drawn between patient safety with appropriate monitoring versus the depth of anesthesia utilized. Failure of boards and societies to recognize this critical advancement of care in procedural pain management will force plastic surgeons to maintain hospital privileges when otherwise these would not be required if their practice is limited to local-only anesthesia. Additionally, early recognition of this evolutionary trend in the place of service will guarantee that boards and societies remain on the forefront of establishing safety standards.

Another facet of this move to local-only anesthesia care is that as plastic surgeons mature along the practice journey, they may consciously shift work toward out-patient procedures. This actively further decreases market share for hospitals. As the shift to local-only anesthesia care grows, it makes maintaining active in-patient privileging of plastic surgeons more onerous and is certainly not equitable. The generation of surgeons that was first affected by the elimination of lifelong grandfathered board certification in the 1990s and required to maintain a time-limited certificate is now facing the tail end of the practice journey. A surgeon who is solo or in a small group simply may not have the access to colleagues willing to take on-call responsibilities at the in-patient level. The ASPS, ABPS, and ABMS must recognize the diversity of revenue streams used by members as they age. ASPS and ABPS leadership must aggressively revisit the requirement of members maintaining privileges at a local hospital as a metric of quality since it potentially and unfairly harms those plastic surgeons in solo or small practices who can no longer easily satisfy on-call responsibilities yet who maintain vibrant, safe, and busy practices with local-only anesthesia. It is one thing to urgently drain a postoperative hematoma in a myocutaneous flap patient from earlier that day. Personal and practice schedules can be designed to accommodate such unexpected outcomes. However, being forced to serve on-call several days a month at various local hospitals suturing young children without the benefit of help due to hospital staffing issues is quite another. Quality is paramount. However, maintaining the requirement of privileging in hospitals as a quality

metric will lead some surgeons struggling to keep certification with onerous on-call obligations while facing shrinking reimbursement. One decade ago, the Federal Aviation Administration recognized the role fatigue plays in error and mandated 10 hours of crew rest before commercial flights.¹⁸ Physicians do not have the same legislated benefits. Surgeons exercising professionalism, however, recognize the importance cognitive acumen plays in day-to-day interactions and schedule accordingly. As on-call responsibilities increase though, the revenue stream can be negatively impacted by the No Surprises Act.

HOSPITAL PRIVILEGING IS NO LONGER FREE FROM BIAS

By actively relying on hospital privileging as a means of quality assurance, medical boards and societies do not recognize the changing environment where many healthcare systems are no longer benign entities as they compete for patients. This policy of requiring hospital privileges is outdated as it assumes equity of medical staff membership at the local level. Quite the opposite: healthcare systems are actively aligning with surgeons at specific facilities through employment or professional agreements and subsequently closing membership to others, thereby decreasing competition to protect market share. As hospitals actively market patient satisfaction scores, hospitals—not patients—increasingly demand plastic surgeon involvement for simple lacerations in the emergency department to elevate patient satisfaction scores. Simply stated, hospitals are no longer neutral in who is favored on staff and what requirements are in place to remain. Naming employed surgeons to key leadership positions over independent solo practitioners who are otherwise qualified is a completely legal strategy to advance the mission—both medical and financial—of the facility.

RATIONAL SOLUTIONS FOR PLASTIC SURGEON STAKEHOLDERS

Given the present political situation in the United States, it is unlikely that the No Surprises Act will change

significantly. No organization will support the resumption of surprise medical billing of patients. The root causes of this phenomenon, low reimbursement by payors for complex procedures, has been debated in the United States for decades without successful solution. Certainly, as many medical societies are in fact doing, one method of dealing with the act is to address the mechanics of the arbitration process including the determination of the floor for reimbursement.¹⁹ But while that battle wages, plastic surgeons must simultaneously exercise the Stoic principle of understanding nothing is constant but change. Plastic surgeons must prepare for this economic evolutionary leap which is beyond their control and focus on mitigating the deleterious downstream impact. Given the present structural requirements of the ABPS and ASPS to maintain privileges at hospitals, plastic surgeons must recognize that they soon may be required to shoulder increasing on-call responsibilities at the in-patient level without OON reimbursement or elect to forego maintenance of board certification. Moving to a local-only anesthesia, out-patient focused practice in a free-standing site—while of course maintaining strict quality—is the only way to avoid mandated on-call responsibilities at those hospitals which require it. The inherent difficulties of this new economic environment and the inequity it produces for those in solo or small group practices cannot be ignored.

Logical solutions to this dilemma exist but require a massive cultural shift at both the organizational and personal level of plastic surgery. Offering various flexible pathways to maintain board certification such that an individual can choose based upon his or her location along the practice journey is the best answer. This would be new. Options should include the following:

- Earning required continuing medical education hours obtained at virtually hosted meetings specifically addressing mindfulness of the practicing plastic surgeon towards patient safety at different stages of both the revenue stream and practice journey.
- Submitting case books as done for the Oral Boards, regardless of complexity but rather demonstrating professionalism, will allow maturing surgeons who do not have the benefit of being grandfathered with permanent board certification an equitable means of maintaining certification while working exclusively in out-patient settings. The plastic surgeon should be able to document his or her focus on patient safety regardless of where a case is performed or the difficulty of the case. Objective metrics published by the organization can serve as a guide for those plastic surgeons who migrate to an exclusively local-only anesthesia practice. Furthermore, maintenance of certification requirements must not be monolithically onerous such that plastic surgeons cannot move freely between in-patient versus out-patient revenue models.
- Interacting with trained surgical coaches to help map positive professional goals over time with logical well-established metrics. Trained coaches could visit with plastic surgeons whose practice is entirely in an out-patient environment. These confidential interactions would never be punitive in nature but instead offer evidence-based strategies to identify and close gaps

in patient safety which are rooted in interpersonal interactions that may be more difficult for a solo or small group practice to monitor or identify. Having trained surgical coaches visit with practicing surgeons positively promotes professional development.²⁰

This is new territory for both the organization and individuals, as those who were first issued the time-limited certificates a quarter century ago are approaching, if not already within, a new phase of their careers. Nevertheless, it is critical as a profession we are mindful of these issues at an organizational level. We must be proactive in addressing these developments; otherwise, plastic surgeons wishing to maintain certification while following the trend to out-patient care will be unfairly required to fulfill increasing in-patient responsibilities with decreasing reimbursement.

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