

Cosmetic Surgery Estimator Webinar

June 24, 2009

Text Transcript

>> Thank you for your cooperation. It is now three minutes after 9:00, and I would like to get started. Good morning. My name is Charisse Gates. I am a senior health policy analyst here at Altarum Institute. I am also the task leader for the Cosmetic Surgery Estimator, and this is the Cosmetic Surgery Estimator Version 5.0 update.

Let's start with the agenda. Today we're going to give a bit of background about cosmetic surgery in the Military Health System, which is Policy—HA Policy 05-020. We're going to talk about the availability of cosmetic surgery and patient responsibilities. We're going to go through the basic process, which includes the purpose of the Cosmetic Surgery Estimator. We're going to go through the cost of elective cosmetic procedures, the discounts available to our patients—I'm also going to go over the Version 5 application changes, the superbill update, and the user's guide. We'll go through several practice scenarios, and then I'll give you information about distribution of this update and the effective date of the rate. I will also open the line at the end of the teleconference for questions and answers.

Elective cosmetic surgery is not a TRICARE-covered benefit; however, Health Affairs Policy 05-020 authorizes elective cosmetic surgery in limited numbers in military treatment facilities to support graduate medical education, board eligibility and certification, skilled maintenance for certified specialists. The policy also notes that during our wartime mission, demands of specialist in these areas are necessary. The skills necessary for reconstructive surgery for wounded warriors are the same that are necessary for performing cosmetic surgery cases, and therefore military providers with these skills have a valid need to perform cosmetic surgery cases to maintain these specialty surgical skills.

The availability of elective cosmetic surgery procedures: MTFs provide these services only on a space-available basis. They're limited to TRICARE-eligible beneficiaries, which includes TRICARE for Life beneficiaries and those beneficiaries who will not lose eligibility for at least 6 months after the surgery will take place. When MSA clerks process a cost estimate for a patient, they should look into the DEERS database to check enrollment status for the patient. Any active-duty personnel who wishes to have cosmetic surgery must have written permission from their unit commander before scheduling elective cosmetic surgery. All patients, including active-duty personnel, are fully responsible up front for all surgical fees; applicable institutional charges; anesthesia charges; and the cost of all implants, cosmetic injectables, and other separately billable items associated with elective cosmetic procedures. All elective cosmetic surgery procedure fees must be paid before surgery can be scheduled.

Acknowledgment of terms: All cosmetic surgery patients must be informed prior to surgery that follow-up, including revision of any surgery performed at the military treatment facility, is not guaranteed in the direct care system and that complications of cosmetic surgery procedures are excluded from

coverage under TRICARE. Any complications that arise from receipt of elective cosmetic surgery are not TRICARE-covered benefits. Patients are fully responsible for those procedures as well. The patient's medical record must contain a signed acknowledgement of this disclosure.

What is the basic process for billing elective cosmetic surgery? Initially, the patient will present for a surgery consult. The surgeon examines the patient and determines whether or not the procedure is sought is elective cosmetic surgery, medically necessary, or reconstructive. If the surgery is determined to be elective cosmetic surgery, the surgeon will complete a Cosmetic Surgery Estimator superbill. The patient takes the superbill to the MSA clerk, who enters the information into the Cosmetic Surgery Estimator, prints a report, and gives it to the patient. This report gives the estimate price to the patient, who then takes it over to the cashier, pays for the surgery in advance, and then has the surgery scheduled.

What's the purpose of having the Cosmetic Surgery Estimator? The main purpose is to simplify cosmetic surgery estimating and billing process, to create more accurate estimates, consistent billing procedures, and to have an automatic generation of estimates.

The cost of elective cosmetic procedures is composed of several different factors, some of which being the professional charges, which are the surgeon fees, which differ by the location of service, which includes a facility fee. However, there is no facility fee for procedures performed in a provider's office. There are also applicable anesthesia fees for particular procedures. The cost of implants and pharmaceuticals, such as breast implants, chin implants, Botox, and Restylane, are also fully chargeable to the patient. All patients must reimburse MTFs at cost for these items. These fees together total the entire cost for the elective cosmetic procedure.

This is the Version 5.0 main screen. And in terms of functionality and layout, there aren't very many changes from Version 4.0. We have Section #1, where you create the inquiry; Section #2, where you generate a report; and Section #3, where you have the option of saving, removing, or resetting an inquiry.

Now I'm going to go over—give you an overview of the changes from Version 4.0, which is 2008; to Version 5.0, which is 2009. First you'll notice there are several nomenclature changes. For example, Box #8 now says "Add-On Code" instead of "Associated or Conjunctive Procedures." This nomenclature change was made to make it more in line with actual AMA CPT coding nomenclature and also to be more descriptive. We've also collapsed the fields for general and monitored anesthesia care. The formulas used to generate the cost for these procedures are identical. There's also been an addition of new procedures for this year based on input received from TMA's Office of the Medical—of the Chief Medical Officer. Box #10 no longer references fillers alone, because Botox and fillers are now located in this box. Instead, it references what pharmaceuticals will be provided by the MTFs. There's a new rate methodology for calculating the facility cost. There's also a new rate methodology for calculating anesthesia costs. In addition, we've built in a new discount for institutional and anesthesia charges when an elective procedure is combined with a medically necessary procedure. And my absolute favorite: We've concluded a CPT glossary to give you more information about each procedure.

Let's give—talk about the new rate methodology. You are going to see some changes in prices. And at first glance, they may look like the prices have increased drastically. But I want to give you a little bit of background and tell you exactly what the changes are. In previous versions of the Cosmetic Surgery Estimator, the OR outpatient setting rates for the facility fees were based on both ambulatory surgical center rates as well as ambulatory payment classification rates, and the price chosen was the lower of the two rounded to the nearest \$10. Based on changes in Medicare and TRICARE, we have adopted the new methodology of using ATC rates only. Medicare is phasing out ASC rate methodology, and so, to move towards that, TRICARE is also adopting the methodology. In some instances, you will find that the ATC rate is higher than the ASC rate was, so some of your facility fees for outpatient locations will increase. But what does that mean about the prices?

So let's go to our favorite—"What are they charging downtown?" Let's compare the new prices with the prices downtown. Here's a civilian cost comparison. Even with the new increase in prices, you can see that the MTF fees are still much lower than the prices in the civilian sector. We're the yellow; they're the blue. And for example, for liposuction in the military, you'll be paying an average of \$1,030; whereas downtown, you'll be paying \$2,868. And for breast augmentation, there's almost \$4,000 downtown and less than \$6,000 in the military. So even with the price increases this year, we are still very competitive with our surgeon fees.

Let's look at the new rate methodology for OR inpatient. Previous methodology utilized a universal elective cosmetic surgery inpatient rate. Every procedure had the same inpatient rate, which was \$5,280, and it was all based on the same DRG. This year, what we've done is approved DRGs by procedure and to account for price variances. We've also chosen to use the TRICARE MSG—MS-DRG conversion factor, which is \$4,696.60. The TRICARE MS-DRG conversion factor does not include the professional fee or anesthesia cost, so these costs are added to that. And then, again, we round them to the nearest \$10. Well, what does that do to the prices? The new inpatient prices range now from \$890 to \$10,600, whereas before, every procedure was the same at \$5,280. The average inpatient cost for this year is \$5,350.67, which is only a 1.4% increase in price. The \$10,000 procedures are the facial reconstructive—those procedures that are very time intensive, labor intensive, and very difficult to do. And also it's based on consumption of resources, length of stay in the hospital, and other various factors.

New rate methodology for anesthesia: In the past, the methodology for calculating anesthesia was to multiplied the TRICARE position factor by the number of base unit. This year, we've added the average time unit to the formula, and that is to account for the intra-operative time. Base units account for the pre- and post-operative evaluation but not the interoperative time. Time units are calculated in 15-minute increments, and for each procedure, the average time for that procedure was used.

I'd like to ask all the participants, if you have not muted your phone, to please do so to reduce the feedback for the other listeners. Thank you.

There's also a new rate methodology for anesthesia, and here's how that reflects in the prices for anesthesia. There is no charge for topical or local blocks. Moderate sedation, as it was last year, is a flat

rate of \$100. General and monitored anesthesia care range this year from \$160 to \$530, and that's with—including the extra units for the average time. Last year's range was \$80 to \$860. So we have reduced the price on some, and for some, the price has increased.

Let's talk about the discounts available. There are three main discounts.

>> Hi, I'd like to ask that if there's anyone who hasn't muted their phone—to please do so. Thank you.

>> There are three main discounts for bilateral procedures, quantitative procedures, or additional sessions. Quantitative procedures are those procedures that are done multiple times in the same manner—for example, lesion removal. And additional sessions are things that are done in separate visits—for example, if you have laser tattoo removal and the entire tattoo cannot be removed in one visit. The third standard discount is for multiple procedures, procedures that are done at the same surgical encounter. And these discounts are—the price for the discount is based on the primary CPT code, which is the procedure with the highest professional fee for any discount. If you're calculating an estimate from more than one procedure at a time, you must start with the CPT code that has the highest professional fee before any discount.

Next the discount is determined by the location of service: either the provider's office, OR outpatient, OR inpatient. As you can see, for the provider's office, any of these three types of procedures results in a professional fee discount of 50%. For OR outpatient, the applicable discount is a professional fee reduced by 50% for the second procedure and also a facility fee discount by 50%. For OR inpatient, the second procedure is \$1,000 flat rate, which includes the facility fee and the anesthesia charges. The fourth discount, which is not related to the location of service but rather the procedure, is a dermatology resident discount for chemodenervation procedures only, which is Codes #64612, 64613, 64614, and 64650. For these procedures, the professional fee is a flat rate of \$50. This discount does not apply inpatient, as inpatient charges do not have a separate professional fee; they are included in the DRG price.

The new discount I referenced earlier is combining medically necessary procedures and elective procedures together. Here you would start with the elective procedure that is requested from the patient. The professional fee is charged at 100%. And if the procedure is done in the provider's office, there is no applicable discount, because there is no facility fee for this location of service. For OR outpatient, the facility fee and the anesthesia fee are both discounted by 50%, and the same if the procedure is done OR inpatient.

This year, 124 new procedures have been added to the Cosmetic Surgery Estimator. Some of those procedures include removal of skin tags, shaving of epidermal or dermal lesions, wound excisions and repairs, facial reconstruction, and corneal refractive surgery.

Botox and fillers: The cost of Botox will no longer be included in the price for chemodenervation procedures. One of those reasons is because the current methodology is not compatible with the procedure discount policy. The HA policy requires that patients pay MTFs 100% of any implants or cosmetic injectables that are provided for a procedure. And if the chemodenervation procedure is

chosen as its secondary procedure, you would end up discounting that drug by 50%, and the MTF cannot absorb the price of a pharmaceutical for patient benefits. This also does not allow for the addition of Botox to non-chemodenervation procedures—for example, brow lift. The 2009 rate for Botox is \$5.41 per unit. This price is standard for all MTFs and has been prepopulated into the two. I will show you this during our practice scenarios.

We have also added additional fillers to the list. And as you can see here, we have ArteFill, CosmoDerm, silicone, and several others. These will all be in a dropdown list, in addition to the Restylane and Radiance that were available last year.

Here is a view of the Cosmetic Surgery Estimator 5.0 superbill. The instructions for the superbill are the same as last year: Circle the procedure description; enter—check the bilateral column if it applies, if it will be done in mirror images of the body; and enter a quantity if applicable.

Practice Scenario #1: Medically necessary procedure plus an elective cosmetic procedure, calculating the discount for this procedure. A 35-year-old female is scheduled to have an abdominal hernia repaired and requests a mini-tummy tuck to be performed at the same time. The procedure will be performed in OR outpatient setting with general anesthesia. The CSE will be filled out in this manner. At the top, you will see there is a question that says, “Will this be combined with a medically necessary procedure during the same surgical encounter?” And the physician has indicated, “Yes.” And the description of abdominoplasty only, which is a mini-tummy tuck as defined by the CPT code, has been circled.

Okay, I’m going to go to the Cosmetic Surgery Estimator, and we are going to calculate an estimate for that scenario. The code provided to us on the superbill was 17999-Y5831, abdominoplasty. And I’m going to use this opportunity to give you an example of the CPT glossary. I’ve had several questions that came through the helpdesk regarding the mini-tummy tuck. And if you click on the button that says “CPT Glossary,” the follow—a box such as this pops up and gives you a description of what is happening in this procedure. And here it tells you that excessive skin and tissue are elevated off the abdominal wall; fat is excised but not extensive, not like a panniculectomy, which is Code #15830; and there is no revision of the umbilicus here. The superbill gave us the information; this is going to be provided in OR outpatient setting. And number—the Box #4 is where you’re going to indicate that this procedure is going to be combined with a medically necessary procedure. And once you check Box #3, that it’s OR outpatient, the tool automatically populates that the facility cost is \$720. Once you check “Yes” in Box #4, it automatically discounts that by 50%. So if we check “No,” it’s \$720, and checking “Yes” makes it \$360. Will this procedure be bilateral? An abdominoplasty is not a bilateral procedure. Will anesthesia be used? General, monitored anesthesia care—and I want to go back up to Box #4 for a moment to show you that both the facility cost and anesthesia cost are discounted when you combine with the medically necessary procedure. If I were to check “No,” the facility cost will be \$720, and this is the cost will be \$400. But checking “Yes” reduces the anesthesia cost down to \$200. Will additional procedures be performed during the same visit, Box #11? The answer is no. Will implant or other noncovered supplies be supplied by the MTFs? The answer, again, is no. So the total cost for this patient to have a mini-tummy tuck during the same surgical visit as her abdominal hernia repair will be \$1,100. I’m going to clear, reset our inquiry, and we’re going to go back to the slide.

Okay, Scenario #2: Chemodenervation. A 50-year-old male suggests Botox injection for unsightly crow's feet and embarrassingly sweaty palms. Sounds like a good idea. The procedure will be performed in a provider's office but not by a resident with topical anesthesia. The superbill will be filled out as follows. For the crow's feet, we will choose Code #64612, chemodenervation facial; for the sweaty palms, chemodenervation extremity, 64614. And since Botox is no longer included in the price for those procedures, we are also going to choose Botox, which is J—Code J0585. Because he's having both hands done, the box for "Bilateral" under 64614 has been chosen. And the cost for Botox—we are guesstimating that it's going to be 40 units of Botox, 20 per procedure here, at \$5.41 per unit.

Let's go to the application and generate a cost estimate for this. The first procedure elected was for the crow's feet, which was CPT 64612. Box #3: Where will the procedure be performed? In a provider's office. You get a box that reminds you that this is a chemodenervation procedure and that you should answer the questions regarding whether or not a dermatology resident will be performing this procedure and whether—and the number of units of Botox to be applied. Boxed #4: Will this procedure be combined with a medically necessary procedure? The answer is no. Will a dermatology resident be performing the procedure? No. Will the procedure be bilateral? Not for the first procedure. Will anesthesia be used? Topical anesthesia. Box #10: What pharmaceuticals will be provided by the MTFs? You use the dropdown menu, and we're going to choose "Botox." As you can see, the price of \$5.41 per unit has already been populated for us. We said we were going to do 20 units per procedure. Putting in a brick 20 automatically calculates a pharmaceutical cost of \$108.20. Will additional procedures be performed during the same visit? The answer is yes. And this takes into a second screen to add additional procedures. We'll select it by CPT code, which is 64614, chemodenervation extremity. You get the same reminder that this is a chemodenervation procedure and please check the resident box if applicable and to add the Botox units. A resident will not be providing this procedure, but it will indeed be bilateral, so you will check the "Bilateral" box here. On this screen, the Botox and filler box is located in the upper right-hand corner. There's still a dropdown box. You click "Botox." And it reminds you to please enter the quantity. The unit price of \$5.41 adds up for us. We're going to add another 20 units. And the total price to have this procedure done bilaterally with 20 units of Botox is \$268.20. Click "Close the Screen," and you will see on Box #11 the additional procedure cost is the same from the other screen: \$268.20. So the total cost for these two procedures plus the Botox is \$516.40.

I'm going to take this opportunity to show you what the report would look like for this patient. So you go down to the bottom of the screen and click "View Report." I'm going to enlarge this so you can see. And this is what the Cosmetic Surgery Estimator cost report looks like. It gives you the primary CPT code, the CPT description, the date and time of the estimate, and it breaks down all the costs: the professional fee, the facility fee if applicable—there's no facility fee here, because we chose that it was done in a physician's office, and there's no facility for a physician's office. And down here, you can see additional or associated procedures, and that's our secondary CPT code and the total cost for that. And at the bottom of the cost report is the total cost payable by the patient. I'm going to reset that and go back to our slide.

Okay, Scenario #3: We're going to talk about the—we're going to go talk about the add-on code. Here we have a 63-year-old woman who requests removal of a total of 30 skin tags on various parts of the

body. The procedure will be performed in a provider's office with a topical anesthesia. The superbill would look as follows: Codes #11200 and—for the first 15 skin tags removed and Code #11201 for an additional 15.

Let's go to the application. So as I mentioned earlier, some procedures are considered secondary procedures and can only be done in conjunction with other procedures, and therefore they're called add-on codes. So in this example, we have Code #11200, which is removal of skin tags, any area up to and including 15 lesions. So for this one, we choose this code and a provider's office—will not be combined with the medically necessary procedure. And in Box #8, you see we are now able to choose an add-on code. And we're going to choose 11201, which is the additional skin tag removal. And I'm going to put in another number here. And if you see here, add-on cost—it automatically adds the cost of this number of additional procedures. Topical anesthesia; no additional procedures during the same visit; no other supplies. The total cost for this procedure is \$370. And it's a good time for us to take a look at the CPT glossary again: What is removal of skin tags? There we go. And it also gives you guidance about which codes to choose. As the last sentence says, reports 11200 for up to 15 regions and 11201 for each additional 10 lesions or part thereof beyond initial 15.

I'm going to reset my screen, and I'm going to go back to the slide, please. Okay. And so, the user's guide will be updated and available with the next version. And this is just a reminder of what it looks like for our returning users and information for our new users. You can see here that the user's guide has step-by-step directions about how to use the application, and it includes screenshot. Now, in regards to distribution of materials for this year, there will be no CDs for the Cosmetic Surgery Estimator Version 5.0. Instead, the CSE database and all associated materials, including the superbill, the letter of acknowledgement, the user's guide, and any other materials necessary, will be available from—for download from a secure Altarum SharePoint Internet site. The files will be password protected for controlled access. The Internet address and passwords, which will be assigned for each site, will be distributed to the UBO service managers, who will disseminate the information to the appropriate staff. Only persons who have the password that are assigned to this specific site will be able to download the material.

The cosmetic surgery rates are included in the Calendar Year 2009 outpatient itemized billing rate package, which is scheduled to be effective July 2009. The process of getting that signed off is going on as we speak, and we anticipate that they will become effective on July 1. If there is any change, I will communicate that information with the service managers, who can disseminate that information to the field.

Are there any questions? That concludes the slide portion of this presentation, and if anybody has any questions that weren't answered earlier, I'd be happy to answer them now.

>> Yes, ma'am. I'm calling from Fort Meade. I want to know how can we get the new rate cost, because I don't have that on my computer.

>> You don't have what on your computer?

>> New rates.

>> The new rates?

>> For the Cosmetic Surgery Estimator.

>> Right. It's not available yet.

>> So I have somebody that's having surgery on the 8th of July. She comes in, and I print her out an estimator. It's not going to be accurate.

>> You're absolutely right.

>> We may overcharge or undercharge that person.

>> Yes, you're absolutely right. And what I would suggest is that you have that person—you run an estimate again for that person after the new rates are available. They do become effective on July 1. So they should be used for any surgery scheduled after July 1. But at this time, they aren't prepared and ready for download yet. But I will let you know as soon as possible when they are ready.

>> Okay, thank you.

>> So I apologize for any inconvenience. We wish we could have had them to you already, but technical difficulties as they are, you will have them soon.

>> Thank you.

>> You're welcome. Are there any other questions?

I also mentioned that there were several new procedures this year. There were a couple of deletions of procedures this year. There is no longer CPT codes on the superbill for premalignant lesions. It was determined that those procedures are always medically necessary, and therefore we need not charge the patient for those procedures. They are no longer considered elective cosmetic surgery. And also the combination procedures—for example, a partial lower-body lift, which originally included a thigh lift and a buttock lift—it won't be listed on the superbill as a partial lower-body lift, but both procedures will be listed separately. And if you price them together, you will receive the same discount as if they were priced together. The first procedure is 100%, and the second procedure is 50%—and the same for the combination procedure, which was called a total lower-body lift, which was an abdominoplasty, thigh lift, and buttock lift. The first procedure was 100%, and the second two procedures were 50%. It will still be priced the same; they're just listed separately on the superbill this year.

>> I have a question, please. Will this presentation, audio as well as video, be available on the UBO Web site?

>> It will be.

>> That I missed—okay.

>> I'm also going—we had technical difficulties with the presentation that was given yesterday. I am going to contact the service managers to see if they would like me to give one more live presentation. And after that, we will set up a recorded version, and it'll be on the UBO Web site in the learning Center under Web training. Last year's version is still up. You can view that one, and it will be there for you to access at any time.

>> Thank you.

>> You're welcome. Is there anything that I didn't cover that anybody would like information about?

>> Hello?

>> Hello?

>> This is Valerie calling from [Indiscernible]. I need to know—

>> In Augusta?

>> Yes. There are two procedures being—with the first one listed on the superbill—will the first CPT code on the superbill be the primary code? Or how would we know?

>> You'd have to go in and put—well, okay, there's one near the rate table that will also be posted on the Web site. And you could look up each procedure to see which one has the highest professional fee, or the easier thing to do is just to type in the CPT code for each procedure separate and click the proper location of service in Box #3 and see what the professional fee is. And whichever one comes up with the higher professional fee, that's the one you price first; and the one with the lower professional fee—that's the when you put into the mo—the second sheet. It's just like, you know, if you buy one, get one half off, equal or lesser value. Yeah.

>> Okay, thank you.

>> You're welcome.

>> I have on the screen right now information for the UBO helpdesk phone number and email address. If you have any questions or like additional information about anything presented here today or anything else regarding cosmetic surgery or UBO—TMA/UBO policies, procedures, or practices, please feel free to give us a phone call and—or email, and your question will be routed to the appropriate person. I hope that you all have gotten some useful information from this presentation. I am pleased to present the information to you, and I thank you for joining us. If there are no more questions—are there any more questions? If there are no more questions, I will end the teleconference now, and I appreciate your time and patience. Thank you very much.

>> Thank you.

>> Thank you.