postoperative complications and excellent patient satisfaction. The hospital resources required to provide comprehensive gender-affirming care, and scheduling conflicts with emergent procedures, negatively affected efficient care delivery. Ultimately, a financial assessment led the ZSFG administration to outsource comprehensive FFS to a nearby academic hospital. Future efforts should continue to expand access to gender-affirming surgery for underserved populations, with an eye toward sustainability from a cost and healthcare utilization perspective.

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The Implications of Same-day Discharge after Primary Unilateral Cleft Lip Repair: An NSQIP-based Study

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**INTRODUCTION:** Orofacial clefts are the most common craniofacial anomaly observed in the United States. Permitted by recent advancements in anesthesia and multimodal pain management, there has been a trend toward outpatient cleft lip repair to alleviate hospital burden and minimize healthcare costs. The purpose of this study was to compare complication rates between outpatient and inpatient cleft lip repair from large national samples as well as identify preoperative factors that predicted discharge status.

**METHODS:** The NSQIP database for pediatrics was used to analyze 30-day outcomes for all patients undergoing cleft lip repair (CPT code 40701) from 2012 to 2019. Complication rates were compared across three groups: same day discharge, next day discharge, and later discharge. Preoperative factors, including comorbidities and demographics, were analyzed to determine the impact of discharge date on complications as well as identify independent predictors of discharge timing and perioperative complications.

**RESULTS:** A total of 6689 patients underwent primary cleft lip repair, with 16.8% discharging on day of surgery, and 72.4% discharging 1 day after surgery. Complication rates were statistically equivalent between same day and next day discharge. Preoperative factors predicting complication and postoperative admission included age less than 6 months and weight less than 10 pounds at the time of surgery. Patients discharged after more than one day in the hospital had higher rates of complications as well as more preoperative comorbidities.

**CONCLUSIONS:** Complication rates between same day and next day discharge are equivalent, suggesting that same day discharge is a safe option in select patients. Clinical judgment is critical in making these decisions.

Endoscopic Strip Craniectomy for Metopic and Sagittal Craniosynostosis: Does Helmeting Time Matter?

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**BACKGROUND:** Craniosynostosis is the premature fusion of one or more cranial sutures, leading to restriction of craniofacial growth. The most common types of craniosynostosis are metopic (MC) and sagittal (SC), leading to trigonocephaly and scaphocephaly, respectively. As a result, disproportionate changes occur in cranial vault asymmetry index and cranial index, which are expected to trend toward normalization after cranial vault reconstruction or endoscopic strip craniectomy (ESC) with postoperative helmet therapy. ESC when compared with cranial vault reconstruction has been shown to decrease operative/anesthesia time, blood loss, blood transfusion, and length of hospital stay as well as earlier onset of surgical intervention. For ESC, however, the postoperative duration and compliance of helmet therapy is crucial to correct MC and SC asymmetry. There are no studies to our knowledge comparing helmet therapy duration for MC and SC. The purpose of this study was to assess the period of postoperative helmet therapy and determine differences, if any, between MC and SC.

**METHODS:** A single institution retrospective review was performed from 2015 to 2019 for patients with MC and SC.
SC who underwent endoscopic strip craniectomy. Patients received immediate postoperative strip craniectomy 3D photogrammetry for helmet therapy planning and implementation as well as posttherapy completion 3D imaging from Cranial Technologies. Institutional IRB approval was obtained. Deformetrica was used to measure cranial length (anterior to posterior), width (left lateral to right lateral), and diagonal (30 degrees from the center of the nose for left and right sides) to compare prebanding and postbanding therapy 3D imaging of MC and SC patients who underwent ESC. These values were entered into Excel spreadsheet and Jamovi v1.2 (2021) to calculate cranial vault asymmetry index (normal: ≤3.5) and CI (normal: >75) and perform data analysis. A multivariate linear regression model was created utilizing significant univariate factors ($P < 0.2$).

**RESULTS:** There were a total of 14 MC and 28 SC patients who underwent endoscopic strip craniectomy at a mean of 3.29 ± 1.12 and 3.43 ± 1.34 months of age ($P = 0.738$), respectively. When comparing both cohorts, MC patients were found to have completed helmeting therapy at a younger age (7.88 ± 2.07 versus 10.0 ± 2.42 months, $P = 0.007$), with a shorter duration (4.17 ± 1.86 versus 6.00 ± 2.15 months, $P = 0.009$), and less number of bands (1.54 ± 0.51 versus 2.21 ± 0.70, $P = 0.002$) than SC patients. After linear regression analysis controlling for postoperative skull base asymmetry, mid-face asymmetry, cephalic index, and standard deviation, suture type was found to be a significant predictor of total time in band therapy ($P = 0.039$), with SC requiring a longer duration of helmeting therapy when compared with MC.

**CONCLUSIONS:** ESC has become a reliable and more common treatment method for MC and SC with postoperative helmet therapy to guide direction of cranial expansion. Suture type directly correlates with duration of helmet therapy for patients, with SC patients requiring longer periods of postoperative helmeting and increased number of bands when compared with MC.

**Trends in Medicare Reimbursement for the Top 20 Surgical Procedures in Craniofacial Trauma**

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**PURPOSE:** Research regarding financial trends in craniofacial trauma surgery is limited. Understanding these trends is important to the evolution of suitable reimbursement models in craniofacial plastic surgery. The purpose of this study was to evaluate the trends in Medicare reimbursement rates for the top 20 most commonly utilized surgical procedures for facial trauma from 2000 to 2021.

**METHODS:** The 20 most commonly utilized Current Procedural Terminology codes for facial trauma repairs from 2000 to 2021 were queried from The National Summary Data File from the Centers for Medicare & Medicaid Services. Reimbursement data for each procedure were then extracted from The Physician Fee Schedule Lookup Tool. Changes to the United States consumer price index were used to adjust all gathered data for inflation to 2021 US dollars. The average annual and the total percent change in reimbursement were calculated for the included procedures based on the adjusted trends.

**RESULTS:** From 2000 to 2021, the average reimbursement for all procedures decreased by 16.6% after adjusting for inflation. Closed treatment of TMJ dislocation and closed treatment of nasal bone fractures without manipulation demonstrated the greatest decrease in mean adjusted reimbursement at −48.7% and −48.3%, respectively, whereas closed treatment of nasal bone fractures with stabilization demonstrated the smallest mean decrease at −1.4% during the study period. Open treatment of nasal septal fractures with or without stabilization demonstrated the greatest increase in mean adjusted reimbursement at 18.9%, while closed treatment of nasal septal fractures with or without stabilization demonstrated the smallest increase at 1.2%. The average reimbursement for all closed procedures in the top 20 decreased by 19.3%, while that for all open procedures decreased by 15.5%. The adjusted reimbursement rate for all top 20 procedures decreased by an average of 0.8% each year.

**CONCLUSIONS:** To the best of our knowledge, this is the first study to comprehensively evaluate trends in Medicare reimbursement for facial trauma surgical repairs. Adjusting for inflation, Medicare reimbursement for the top 20 most commonly utilized procedures has largely decreased from 2000 to 2021. Consideration of these trends by surgeons, hospital systems, and policymakers will be important to assure continued access to meaningful surgical facial trauma care in the United States.