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.)

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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. 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 of 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. 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. 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. 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...
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. 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. 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. 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, 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. 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. Conversely, those who support arbitration contend that benchmark payments would give insurers the ability to solely dictate payments, undermining the provider-insurer negotiation process.

### THE NO SURPRISES ACT

In light of the rising incidence of surprise billing, Congress passed the No Surprises Act in December 2020. 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. 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 nonemergency 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 nonemergency 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. 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

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**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, a fee that must be paid 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.

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.](image)
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. 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. 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. 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

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**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.
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. 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...
disclaimers. Instructions and a template for the good faith
estimate may be implemented in plastic surgery proce-
dures and obtained from the CMS website. 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 arbi-
trator 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 pay-
ment 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 con-
sumer 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. Under the
No Surprises Act, commercial health insurance compa-
nies 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 pro-
cess 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

| Insured Patients: Nonemergency Setting |
|---------------------------------------|
| **Normal Scenario**                   |
| **Patient**                           |
| Breast reconstruction patient         |
| undergoing revision at in-network     |
| ambulatory surgical center            |
| **Medical Services Provided**         |
| In-network plastic surgeon            |
| performs breast revision              |
| **Insurance**                         |
| Insurance bills patient the in-network amount for ALL services |

| Clinical Scenario 1                   |
| **Patient**                           |
| Breast reconstruction patient         |
| undergoing revision at in-network     |
| ambulatory surgical center            |
| **Medical Services Provided**         |
| Abnormal mass discovered and specimen sent to out-of-network pathologist |
| **Insurance**                         |
| Insurance bills patient the in-network amount for ALL services |

| Clinical Scenario 2                   |
| **Patient**                           |
| Breast reconstruction patient         |
| undergoing revision at in-network     |
| ambulatory surgical center            |
| **Medical Services Provided**         |
| Patient develops hematoma and out-of-network plastic surgeon evacuates hematoma in OR |
| **Insurance**                         |
| Insurance bills patient the in-network amount for ALL services |

*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.

In the future, plastic surgeons may 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. The majority of the arbitration disputes over emergency services during these 3 years were most commonly attributed to plastic surgeons (40%). 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
how this act impacts surgeon reimbursement and network status.

Regarding uninsured or self-pay patients, who comprise a substantial proportion of plastic surgery care,\textsuperscript{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,\textsuperscript{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.

**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.

| Steps                      | Clinical scenario                                                                 | Timeline |
|----------------------------|-----------------------------------------------------------------------------------|----------|
| Patient requests surgery   | Patient desires rhinoplasty from plastic surgeon                                |          |
| Good faith estimate provided | Plastic surgeon must provide good faith estimate                           |          |
| Date of service            | Patient receives good faith estimate and proceeds with operation                  |          |
| Bill received by patient   | Patient receives bill exceeding $400 more than the good faith estimate           | 120 days |
| Patient-provider dispute resolution requested | Patient submits request for patient-provider dispute resolution process |          |
| Patient-provider dispute resolution initiated | Arbitrator approves request and contacts the plastic surgeon | 10 days |
| Provider submits documentation | Plastic surgeon uploads necessary documents to online portal | 30 days |
| Determination of Payment   | Arbitrator determines the patient’s service payment OR Plastic surgeon and patient negotiate the service payment |          |
| Notification of Settlement  | Plastic surgeon notifies arbitrator of the settlement                           | 3 days   |
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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