to calculate total opioid usage. Length of stay and other direct cost data was collected over the post operative period.

RESULTS: Twenty patients have been enrolled prior to this interim analysis. Ten women were randomized to each arm of the study. Average age was 56.1 years for patients in the control arm and 46.9 years for patients in the experimental arm. Average post-operative pain scores were 3.54 for patients in the control arm and 3.52 for patients in the experimental arm. Opioid consumption, in morphine equivalents, was 167.25 mg for patients in the control arm and 135.12 mg for patients in the experimental arm. Diazepam consumption was 17.22 mg for patients in the control arm and 5.5 mg for patients in the experimental arm. Average length of hospital stay was 43.86 hrs for patients enrolled in the control arm and 32.36 hrs for patients enrolled in the experimental arm. Average ondansetron requirements were 6.4 mg in the control arm and 6 mg in the experimental arm. There were three episodes of nausea and vomiting in the control arm and two episodes in the experimental arm.

CONCLUSION: Early interim analysis suggests that liposomal bupivacaine has the potential to reduce opioid consumption, length of stay, and direct costs. These trends have yet to reach statistical significance, however patient recruitment and data collection is ongoing.

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Reimbursement in Breast Reconstruction: To Carve Out or Cut Out, that is the Question

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BACKGROUND: With greater awareness and federal mandates, the demand for breast reconstruction has grown. Despite this increasing patient population, the uncertainty of physician reimbursement persists; with wide variation based on payor type. Although the technical aspects and time commitments of autologous and expander based reconstruction are the same, regardless of insurance status, the expected reimbursement for these services and potential “revenue loss” could have major implications in patient access to their reconstruction of choice. Some surgeons have attempted to circumvent this issue by developing insurance carve-outs for autologous reconstruction. For those surgeons unable to negotiate this arrangement with insurance carriers, a major concern is that these surgeons will find it financially challenging to offer certain types of reconstructions to all payor types. The purpose of this study is to identify re-imbursement variation among payor type for breast reconstruction procedures at a tertiary academic center in an effort to understand potential financial implications and begin developing safeguards to prevent effects on patient access to all available reconstructive options.

METHODS: Billing and insurance data were collected over a 10 year period for CPT codes 19364 (ABR) and 19357 (IBR). Unilateral and bilateral (-50) procedures were analyzed separately. Patients were categorized by insurance type. Charges and reimbursement were collected and compared using ANOVA testing and a two-sized Student’s T-test with p<0.05 indicating significance.

RESULTS: 1275 women underwent unilateral implant-based reconstruction (UIR), and 1089 women underwent bilateral implant-based reconstruction (BIR). For UIR, charges to Medicaid, Medicare, and private insurance were similar ($4080, $4225, and $4058, p=1). Reimbursement differed significantly between all groups (p<0.001) with Medicaid reimbursing an average of $703, Medicare $1374, and private insurance $3017. For BIR, charges were again similar ($8465, $8220, $8268, p=0.96), however reimbursement for Medicaid was $1250 and Medicare $2082, which differed significantly from private insurance at $4972 (p<0.001). 241 women underwent unilateral free flap breast reconstruction and 109 underwent bilateral. In unilateral cases, charges differed significantly Medicare ($11433) and both Medicaid ($8934) and private insurance ($9429). Reimbursement differed between all groups (P<0.001). Finally, charges in bilateral free flap cases did not differ, but while Medicaid and Medicare had similar reimbursements ($2132, $4134, p=0.6), this differed significantly from private insurance ($6179, p=0.002). Overall, Medicaid reimbursement for breast reconstruction was 15%, Medicare 25%, and private insurance 51%.

CONCLUSIONS: Significant gaps exist between payor reimbursements for breast reconstruction. These gaps pose
serious threats to patient access to reconstruction of choice based on their insurance status.

**Patient Care and Quality Improvement: Utilization of a Novel Risk Calculator to Predict Unanticipated Postoperative Readmission**

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**PURPOSE:** Unanticipated postoperative readmission will be a quality-directed metric linked to CMS reimbursement. In an effort to both optimize patient care and prevent negative financial implications, we have identified patient risk factors that contribute to unanticipated postoperative readmissions for plastic surgery patients. Building on this knowledge, the aim of this current study is to create a risk index calculator to quantifiably predict the likelihood of 60-day postoperative readmissions.

**METHODS:** An IRB approved retrospective review was done evaluating 671 randomly-selected patients undergoing procedures with the Plastic & Reconstructive Surgery service at our institution between January 1, 2013 and December 31, 2014. 60-day postoperative readmissions were identified for 58 (8.6%) patients. Logistical regression and backward variable selection with an inclusive p-value <0.30 yielded patient age, BMI, same-site procedure, renal disease, thyroid disease, CAD, COPD, and history of malignancy as variables associated with readmission.

**RESULTS:** We used a linear combination rule with the associated variables associated with readmission to create a risk index calculator. The product of the risk calculator yields a Risk Index Value (RIV). The RIV corresponds to a Predicted Percentage (PP) representing the probability of a 60-day postoperative readmission.

**CONCLUSION:** Patient risk factors associated with unanticipated postoperative readmissions can be used to calculate the percentage likelihood of 60-day postoperative readmission. With this information, practitioners can provide appropriate resources for patients at increased risk of readmission ultimately satisfying quality-directed metrics linked with CMS reimbursement as well as optimizing the delivery of patient care.

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**Shared Decision Making in Pediatric Plastic Surgery: A Multicenter Prospective Study in a Cohort of Patients with Vascular Malformations**

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**INTRODUCTION:** Shared decision making (SDM) is a communication approach in which clinicians and patients arrive at a joint decision about the best therapeutic action, which is not only medically relevant but also suits the situation and preferences of the patient. The importance of SDM in modern health care is stressed by many physicians and politicians. SDM would increase patient participation, patient satisfaction and therapeutic adherence. Furthermore, it would reduce the use of discretionary therapeutic interventions. However, little is known about the role of SDM in pediatric plastic surgery. In this multicenter prospective study in a cohort of patients with vascular malformations, we investigated patient preferences, the current status of SDM practice and the relationship with patient satisfaction.

**METHODS:** Patients with peripheral vascular malformations who were facing a treatment-related decision, visiting the outpatient clinics of 2 university hospitals in the Netherlands, were prospectively followed. Parents and patients older than 18 years completed several validated SDM questionnaires about their preferences regarding decision making (Control Preferences Scale), SDM-related content of the conversation (SDM-Q-9), the patient’s perspective of involvement during the consultation (CollaboRATE) and patient satisfaction. The physicians completed a physician-specific version of the SDM-Q-9. Furthermore, all consultations were audiotaped and independently assessed for SDM-specific criteria by 2 researchers using the OPTION-5 score.