

## Insurance Coverage: A Patient's Guide



### Staying Informed About Your Health Care Costs ...

As you plan for plastic surgery, you will probably learn a lot about what will happen in the operating room and discuss with your plastic surgeon how you will look and feel afterward. However, another important part of being an informed patient is knowing about the costs associated with surgery and how these costs will be paid.

The American Society of Plastic Surgeons (ASPS) has prepared this information to assist you in better understanding health insurance benefits for plastic surgery. It is intended to answer basic questions and guide you in communicating effectively with your plastic surgeon's office staff and your insurance carrier. It won't answer all of your questions, because a lot depends on individual circumstances and your own insurance. Be sure to contact your insurance company or your employer's Human Resources/Benefits department with any questions you have about coverage for specific services.

### About Plastic Surgery

Derived from the Greek word "plastikos", meaning to mold or give form, the specialty of plastic surgery encompasses two general categories:

- **Reconstructive surgery** is performed on **abnormal** structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function but also may be done to approximate a normal appearance.\*
- **Cosmetic surgery** is performed to reshape **normal** structures of the body in order to improve the patient's appearance and self-esteem.\*

*\*Definitions as adopted by the American Medical Association and the American Society of Plastic Surgeons (ASPS).*

### What's Covered

Your insurance policy is an agreement between you and your insurance company. In contrast, an agreement on services and fees is an agreement between you and your plastic surgeon. When you have surgery, you become responsible for payment of the doctor's fees. Coverage for services and levels of payment by your insurance company depend on the terms of the contract between you and your insurance company. You are responsible for any amounts not covered by your plan.

Reconstructive surgery is generally covered by most health insurance policies, although coverage for specific procedures and levels of coverage may vary greatly.

Cosmetic surgery, however, is usually not covered by health insurance because it is elective. Cosmetic surgery is your choice and not considered a medical necessity.

There are a number of "gray areas" in coverage for plastic surgery that sometimes require special consideration by an insurance carrier. These areas usually involve surgical operations that may be reconstructive or cosmetic, depending on each patient's situation. For example, eyelid surgery (blepharoplasty) — a procedure normally performed to achieve cosmetic improvement — may be covered if the eyelids are drooping severely and obscuring a patient's vision. Or, nose surgery (rhinoplasty and/or septoplasty) may be covered if it will correct a defect that causes breathing difficulties.

In assessing whether the procedure will be covered by the patient's insurance contract, the carrier looks at the primary reason the procedure is being performed: Is it for relief of symptoms or for cosmetic improvement? If a procedure is within these "gray areas," insurance companies often require prior authorization or approval before the surgery is performed and/or extra documentation after surgery to determine how much of the cost of your care they will cover.

### **Reading Your Own Policy**

It's important to understand what's included in your policy before you advance too far in planning surgery. Some policies provide coverage for many plastic surgery procedures while others are more limited in coverage. Read your policy and benefits manual carefully and discuss any questions you may have with your insurance plan manager.

There are three typical cost sharing options:

- A **deductible** is the total amount of covered medical expenses that must be paid by the patient before the insurance company begins paying benefits. Examples of standard deductibles are \$100, \$250 or \$500. After this requirement is reached, the insurer will begin paying according to terms of the contract — often 75 percent to 85 percent — of covered medical costs. The patient is responsible for any remaining balance.
- A **flat-rate copayment** reflects a defined share of covered medical costs that the patient pays with the insurance carrier paying an amount based on the patient's policy. For example, when the patient pays \$15 of any office visit charge or \$3 for any prescription, the insurance carrier is responsible for the balance.
- A **percentage-based copayment** reflects a percentage share of covered medical costs that the patient pays, with the insurance company paying an

amount based on the patient's policy. Examples are: 20 percent of the office visit charge — \$10 of a \$50 charge, \$12 of a \$60 charge, etc. Typically, this copayment arrangement includes a deductible and may have other variations.

Your benefits administrator will be able to explain these points to you. Be certain that all patient financial responsibilities are understood before having surgery. If you can calculate your costs based on the terms of your insurance plan, there will be no misunderstanding later of your obligation.

### ***Example One***

A woman is planning to undergo hand surgery, the surgical fee will be \$2,000. Her plan has a \$250 annual deductible, and will cover 80 percent of her covered medical costs. Because she has paid only \$70 so far this year in covered medical expenses, she must pay the first \$180 of the covered costs of the hand surgery to satisfy her plan's \$250 deductible. If her plan's cost share is a percentage-based copayment of 80 percent to 20 percent, the carrier will pay 80 percent of the covered costs of the procedure. Once that is settled, she must pay for 20 percent of the covered costs, plus any costs for which the insurance plan denies coverage.

If the patient's insurance plan covered the full surgical fee, the cost sharing would look like this:

Reconstructive Hand Surgery: \$2,000  
Balance of deductible: \$180 (\$250 - \$70)  
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\$1,820  
Insurance coverage:  $\$1,820 \times 80\% = \$1,456$   
Patient payment:  $\$2,000 - \$1,456 = \$544$

The \$544 is the patient's responsibility under the percentage-based copayment arrangement.

### ***Example Two***

A different scenario occurs if the patient has met the deductible and the plan covers the full surgical fee. Then the math might look like this:

Reconstructive Hand Surgery: \$2,000  
Percentage-based agreement: \$1,600 (80%)  
Patient payment: \$400

The patient's responsibility is, in this example, \$400.

### ***Example Three***

If the patient's insurance has a flat-rate copayment plan for covered medical services with no other limiting conditions and the copayment rate is \$15, then the surgical cost might be paid as follows:

Reconstructive Hand Surgery: \$2,000  
Contracted patient copayment: \$15  
Balance paid by insurance: \$1,985

#### **Example Four**

With a **coordination of benefits** or dual coverage, the hand surgery patient is also covered under her spouse's insurance, and the benefits of both plans may be coordinated to cover more of the cost of the surgery. With dual coverage, the patient's carrier is considered the primary insurer. Coverage under a percentage-based copayment is 80 percent of the cost of surgery. The secondary insurer, her spouse's plan, may cover the remaining 20 percent depending on the specific terms of the spouse's policy.

After the primary insurer has paid its share, it will send the patient an "explanation of benefits" statement, including the date of service, the doctor's charges and/or hospital covered charges, the amounts and payment dispersal dates. If the patient is covered under only one plan, she must pay the unpaid balance. With dual coverage, the secondary insurer may pay some or all of the remaining balance. Usually, the secondary insurer will not pay for any portion of the remaining balance until a copy of the primary insurer's benefits statement is received.

The above illustrate examples of coverage. The amount billed to your insurance by your physician may not be the actual amount on which reimbursement is calculated; your insurance plan may assign a lesser fee for the procedure. Where a physician has agreed to be a contracted provider, these illustrations will not necessarily apply.

Your particular situation will:

- reflect the coverage and cost-sharing agreement of your insurance plan;
- the deductible and any amount of the deductible that you have already met;
- and any dual coverage available if you are also carried on your spouse's or another secondary plan.

Understanding your policy and your responsibility for payment is essential. Securing approval of medical services and fees by your insurance carrier prior to surgery will prevent any misunderstanding of coverage and responsibility for payment after your care is complete.

#### **Beginning the Process**

When you visit your plastic surgeon's office for the first time, bring your insurance card with you. If you are eligible for coverage under another plan, bring this insurance card with you as well. With verification of this information on file, the plastic surgeon's office staff may bill your health care plan directly for covered services.

Once you and your plastic surgeon have agreed on the specifics of your care and the fees, it's likely that your plastic surgeon will assist in determining if your care is indeed covered by your insurance plan. Your plastic surgeon will probably send a pre-authorization letter to your insurance carrier, explaining the procedure, listing the ICD-9 (diagnosis) and CPT (procedure) codes, the surgical fee, place of service and anesthesia. The pre-authorization letter will request authorization to proceed with your surgery and an indication of the level of coverage provided by your policy. Before giving the "go-ahead" to proceed with surgery, the insurance company will review your case to ensure that the procedure is medically necessary based on the insurance carrier's guidelines of medical necessity.

During this review period, make sure you have a clear understanding of the costs and fees and determine the portion you'll be expected to pay. Remember, if a hospital stay is also required, a number of other costs will be involved.

Keep accurate notes of all communication with the insurance company and your plastic surgeon, and make a personal file to keep copies of completed insurance forms and every letter sent or received. Keep your file in a safe place in case papers are lost in the insurance process or the mail or you need to reference anything about your surgery.

### **The Appeals Process: Another Chance at Coverage**

If your insurance company does not authorize payment for your reconstructive surgery, or if it agrees to pay only a small percentage of a claim, you may choose to appeal the decision.

Before beginning this process, carefully read your policy or benefits booklet. Make sure there is nothing in the plan that specifically excludes the type of care you received or are scheduled to receive.

In appealing the decision, your first step is to write a letter to the insurance company representative (usually the claims supervisor) who signed the notification of denial. In the letter, explain why you feel the procedure should be covered and ask that your request be reviewed by a plastic surgeon certified by the American Board of Plastic Surgery.

Your appeal letter should also request a full explanation of why coverage is being denied or paid at a reduced level. Request that the claims supervisor send you a copy of the specific statement — *drawn from the policy or from the benefits booklet* — that explains why your coverage is limited or denied. Attach a copy of the denial notification and a copy of your doctor's pre-authorization letter to again provide the statement of your surgeon's fee, the applicable billing codes and an ASPS Position Paper specific to your procedure. Position papers are available from your plastic surgeon.

If you receive a vague response, or an explanation that "your policy does not cover this type of surgery," you have the right to see that policy language in writing. Make certain that these policy restrictions were in place when you first began your contract with the health plan and started paying premiums. If the restrictions were not initially in place, you may have the right to coverage under the insurance laws of your state.

Many patients find it helpful to send a duplicate mailing of their appeal letter to the insurance commissioner of their home state for indemnity insurance or to the department of corporations if you are covered under a managed care plan such as a health maintenance organization (HMO). This should include a brief cover letter explaining the trouble you are having and asking for assistance.

If your insurance company responds favorably to your appeal, notify the commissioner of your successful appeal efforts with a second letter.

## **Paying for Cosmetic Surgery**

Your plastic surgeon practices in an ethical manner and will submit claims to insurance carriers only for valid reconstructive plastic surgery. Any attempt to misrepresent a cosmetic procedure as reconstructive is unethical. Cosmetic procedures are elective, and payment is the responsibility of the patient.

Some plastic surgeons accept major credit cards or offer financing programs that allow patients to make manageable monthly payments for cosmetic surgery. Ask your surgeon's office staff if any such programs are available.

## **Glossary of Terms**

**ASPS Position Paper:** a written statement by the American Society of Plastic Surgeons detailing the background and medical indications for reconstructive and cosmetic surgical procedures. Position papers covering the most common plastic surgery procedures are available.

**Copayment:** in a contract with a health plan, the portion of covered medical costs that the patient pays. In a typical plan, the patient's copayment may be based on a percentage or a flat rate.

**Coordination of Benefits:** occurs when a patient is eligible for coverage by more than one insurance plan. The benefits of the plans are coordinated so that the patient may receive up to 100 percent coverage for his or her medical costs.

**CPT Code:** a code number used to identify medical services. Developed by the American Medical Association, "CPT" stands for Current Procedural Terminology. CPT codes are used by physicians in billing for services performed.

**Deductible:** the total amount of covered medical-care expenses that must be paid by the patient, usually on an annual basis, before the insurance company begins paying benefits.

**Exclusion:** a condition or circumstance for which a health plan does not provide benefits.

**ICD-9 Code:** a code that indicates the diagnosis - illness, disease or trauma - for which care was rendered. "ICD" stands for International Classification of Disease. Diagnosis codes must correlate correctly with CPT codes for an insurance carrier to consider payment.

**Pre-authorization letter:** a letter written by a physician to an insurance company prior to surgery. It explains in detail the procedure a patient plans to have and requests confirmation that the patient is covered, the planned services are covered, and the level of coverage for the planned services.

**Pre-determination:** a review process conducted by an insurance company to verify the medical necessity of a planned procedure or treatment. Pre-determination is often a condition of plan payment.



This symbol designates surgeons who are active members of the American Society of Plastic Surgeons. They are certified in the specialty of plastic surgery by the American Board of Plastic Surgery and are dedicated to the highest standards of patient welfare and surgical excellence.

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