SurgeryShopper.com

Add A Medical Travel Program To Your Surgery Cost Containment Strategy

Have you heard?

- Self-funded and self-insured employers can add SurgeryShopper.com's medical travel program for group health into an existing cost containment strategy without changing brokers or TPAs.

- Learn how easy it is to begin saving money on surgery case rates without additional PEPM network access fees and pricey program set-up and administrative fees.

- Choose from an array of pre-qualified and inspected, accredited facilities and physicians and anesthesiologists with verified credentials and privileges.

- Save an average of $100,000 - $500,000 per year on high-cost surgery procedures without crossing U.S. borders.

- Save far more than you could save through reference-based pricing with predictable, advance-negotiated, contracted surgery prices, and protect your plan participants from surprise bills and costly balance billings associated with reference-based price agreements.

It's so easy to modify your SPD to add a medical travel program to your plan.

All it takes is 3 simple paragraphs.

We'll even supply the model language in use by other employers so you can run it past counsel, get it approved and filed, and start saving plan dollars and patient cost shares right away.

PROGRAM BENEFITS

NO FEES. There are no hidden (or transparent) upcharges to access providers in our database.

NO PEPM. There are no per-employee-per-month (PEPM) fees to pay

NO NEW ID CARDS. There are no membership cards to manage or distribute or collect or deactivate if an employee leaves the company.

RELIABLE CONTRACTS. Your contracts are direct with the provider, no middle layers to pay for.

CASE MANAGEMENT. You pay for the care coordination and travel planning for your plan participants need on a flat fee, predictable, per case cost. This fee covers the cost for activities performed by healthcarea and travel professionals with a goal of facilitating appropriate care access across the entire episode of care under your medical travel program. The per case fee is far more economical than paying for a service as a PEPM fee when your beneficiaries are not actively using these services. Across the USA, according to the US Department of Health and Human Services, the average care management fee is $4.34 per person, per month.

SITE INSPECTIONS. Take comfort knowing that every provider has been inspected, and all their license, accreditation and safety data has been verified.

DESTINATION MANAGEMENT. Take comfort that hotels and neighborhoods have been inspected as well.

MEDICAL TRAVEL ARRANGEMENTS. Travel arrangements are ticketed by a licensed and regulated travel agency specially-trained to arrange medical travel.

EXCLUSIVE DISCOUNTS. All available travel discounts are passed on to the patient or group health plan sponsor.

FIRM WRITTEN PRICE QUOTES. Providers review the patient's medical records and images or other studies, offer a telephone conference with the surgeon, confirm the procedure and supply a written quote in advance.

- **EASY INVOICES.** A single-line, bundled price invoice is prepared for each case that reflects the reliable, negotiated price due and payable by ACH or check or pre-loaded debit card. Want them formated as UB-04 or CMS 1500 claims? No problem. Just ask!

- **NO SURPRISE BILLS.** There are no surprises, there's no need for audits or repricing, and provider settlement is a single bundled-payment for the pre-defined Episode of Care.

- **PATIENT FINANCING.** No-interest financing is also available to patients for their out-of-pocket portion, if any. 97% of applicants are approved. Does your plan require prepayment by the patient and reimbursement through a limited-benefit HRA? No problem, our program will advance them up to $20,000 in most cases, which will cover most surgeries and the travel and the case management flat fee. Take 9-12 months to pay with no prepayment penalties. They can use their HRA money to pay off the loan or you can pay off the loan directly.

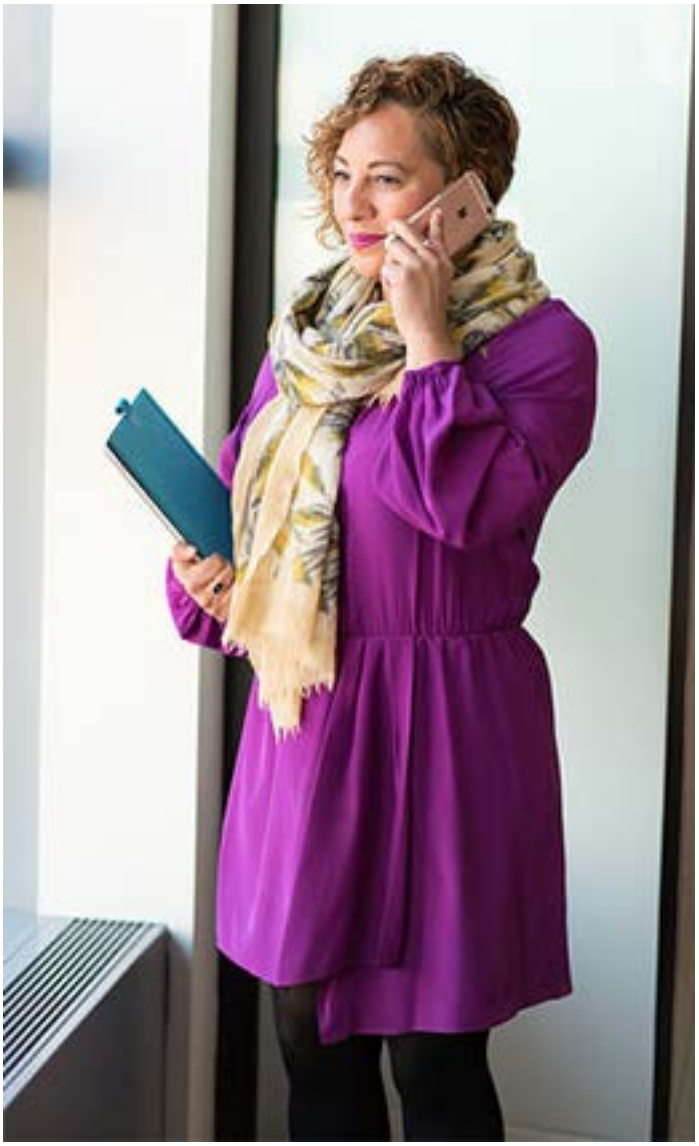
- **EASY PLAN INCENTIVES.** Many employer-sponsored self-funded health benefit plans waive deductibles and copayment amounts as an incentive to use the medical travel program.

- **BENEFITS SATISFACTION.** Some employer sponsored plans save so much on each surgery case that they show their gratitude with a one-time contribution to the employee's HSA or HRA.

- **NO ADDITIONAL HR BURDEN** Your human resources team will love how easy this is to implement and how little time and effort is required from them. Once the case is approved and authorized, we handle all the details.

- **LASERED CLAIMS COST CONTAINMENT.** Employers with financial responsibility for catastrophic health expenses that have been excluded from re-insurance and stoploss programs realize hard dollar savings on every procedure, net, after travel costs have been added in.

- **EASY SPD MODIFICATION.** The addition to the Summary Plan Description (SPD) to add the program as a benefit is a simple three short paragraph modification (we'll even supply the template language for you.)



Small, medium or large groups are all welcome to implement this program and start saving on surgery prices right away!

- **LOWER CLAIM EXPENSE EXPERIENCE.** Change the trajectory on your surgery claim experience. The more your participants use the program, the more you save. In an average of six surgery cases, you can save well over $100,000 in plan assets. Eventually, your underwriter will reset your premiums and reserve accounts to a lower amount.

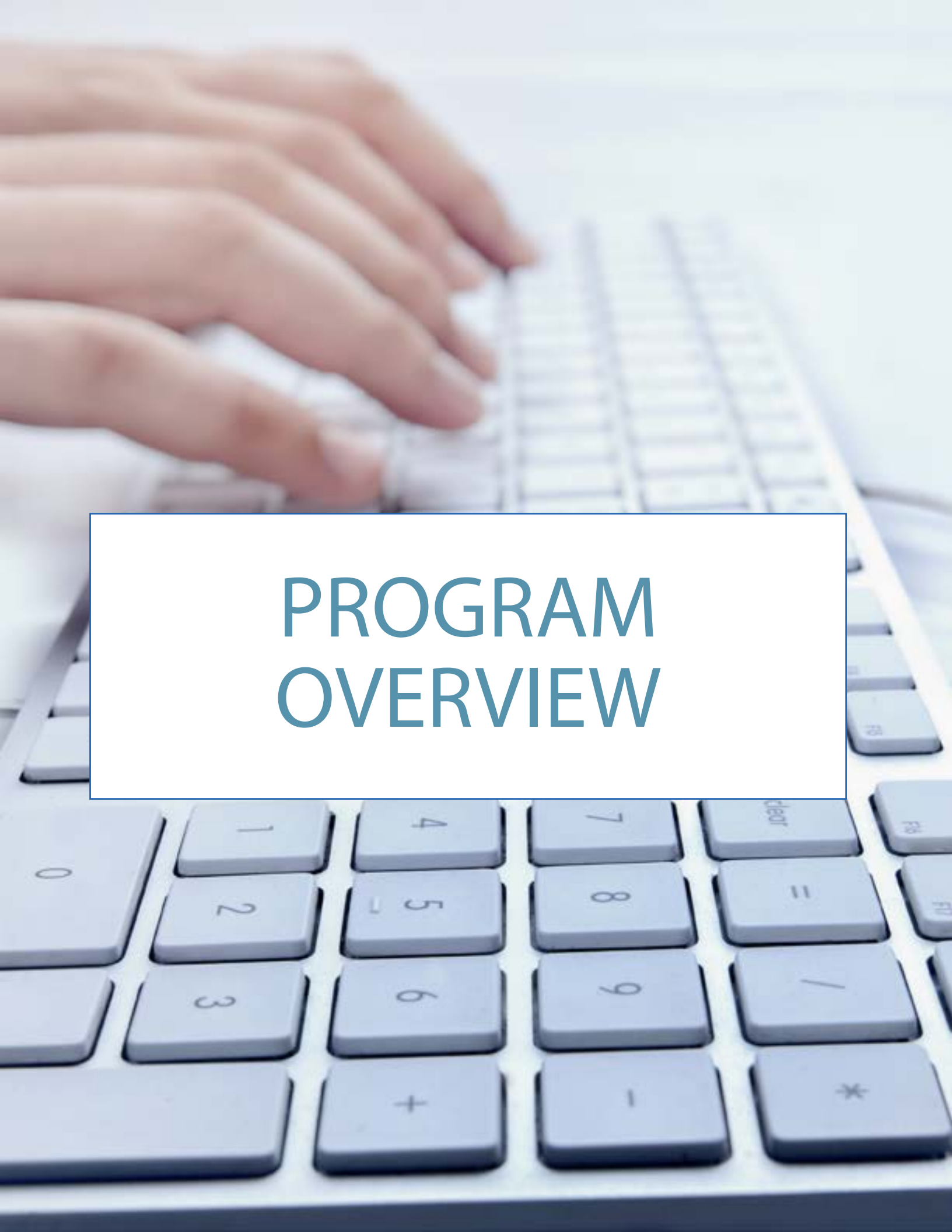
- **PARTICIPANT EDUCATION.** Need some help to explain the program to plan participants? No problem. We will come to your location for a town hall session, supply webinars, a convenient patient portal, a printed program guide for employers and TPAs, and concierge phone and email support throughout their entire journey. (Expense reimbursement, at actual cost, is charged when travel is required).

- **HIPAA COMPLIANT.** it would be our pleasure to execute a HIPAA Business Associate Addendum for you. Our system and practices and procedures are secure and meet requirements of both HIPAA (USA) and PIPEDA (Canada) for full medical records and imaging transfers.

- **POST-OP MANAGEMENT APPS.** We've arranged to supply an excellent digital tool to create personalized treatment plans for your plan participants. Patients often struggle with home exercise programs when recovering from orthopedic, spine and cardiac and abdominal and bariatric surgery procedures or chronic diseases. This clinically-validated app lets surgeons send patients back home with custom exercise and stretching plans for patients or to personalize standard rehab protocols. The app can be used for various types of treatment plans including pre-and post-operative, cardiac rehabilitation, and chronic disease management. Daily reminders and progress tracking help ensure your plan participants stick with the plan laid out by their treatment team both at the destination and after they return home. Available for iPhone, iPad and Android devices. This is a wonderful extra we provide at no additional cost. It is especially valuable for patients who reside in remote and rural areas of the country, and places where weather conditions make driving the physical therapy hazardous or where physical therapy centers are not available nearby.

- **PLAN ADMINISTRATOR FIDUCIARY COMPLIANCE.** Your plan administrator has the fiduciary compliance to save trust dollars and make decisions that are in plan participant's best interests. With SurgeryShopper.com you can do both without delay and frustration. If you haven't added this program to your benefit design, we'll help your plan participants find the procedures and pricing and supply them all the information and documentation you need to grant a quick, out-of-network authorization. Once they've been assisted and are on their way to care, we'll circle back to help you make this program available to other plan participants so you can save even more. Most of our facilities are happy to host you for a site inspection to complete your due diligence, if you like.

- **QUARTERLY SAVINGS REPORTS.** Receive informative and actionable reports that summarize your plan savings to date compared against your negotiated, in-network surgery rates. Get summarized, HIPAA-de-identified clinical outcomes for each case, and de-identified plan participant satisfaction feedback.



PROGRAM OVERVIEW

CASE MANAGEMENT

Case Identification

Prior Review

TPA or Case Manager Referral

Call from Patient, Employer or Provider

Predictive Modeling Alert

Patient Assessment Interview

Claims History Examined
Additional information collected by telephone

Case Not Appropriate

Case Accepted

Episode of Care Plan Development

Alternative sites of treatment evaluated and selected
Specific treatment plan developed
Suppliers of services arranged
Medical records and images transferred
Surgeon interview by phone or web conference
Agreement to plan obtained by patient, physician, faciity and employer

Plan Implementation and Monitoring

Arrangements with service suppliers completed
Transfer of patient and companion coordinated
Surgery performed
Patient status and services monitored and adjusted if needed
Follow-on care handoff to local provider and rehabilitation arranged

Case Closure

Recover and outcomes monitoring
Summary and Analysis Report Prepared and Tendered

How Medical Travel Case Management Works

Across the industry, permutations are numerous, but the basic approach of medical travel case management is fairly straightforward: to bring a competent and knowledgeable team of coordinatators who are concerned with patient care, special needs medical travel arrangements, and cost containment into the process by which patient care decisions are made for patients and their companions who will travel away from their usual place of residence to have surgery.

The four most common elements of medical travel case management programs are:

1. efforts to find less costly alternatives to the local in-network care that would be provided for specific patients in the absence of case management;
2. willingness to approve payment for services from other than local in-network providers, if doing so will help reduce overall costs without safety, quality, or service detraction;
3. agreement from all relevant parties—patient, family, surgeon, anesthesiologist, facility, local physician—in implementing cost-saving alternatives for meeting the patient's needs; and
4. care coordination throughout the entire episode of care, intake handoff, follow up aftercare coordination and oversight of rehabilitation program adherence, outcomes monitoring and feedback and cost analysis and savings recap.

Although the first two of the above elements appear to be virtually universal in in most medical travel case management programs, the third and fourth elements are not, even though it is often described as part of a standardized model. To compare across medical travel programs, ask for sample copies of the reports you'll receive.

The diagram on page 7 charts in more detail the steps that are involved in medical travel case management. The process starts with case identification, proceeds through assessment of the patient's suitability for the medical travel program and the availability of alternative providers of treatment. It continues with the development of a specific plan that is agreed to by all involved parties and then implemented and monitored. The final step is closure of the case. This occurs 60-90 days after the surgery has been performed and is tendered to the employer's plan administrator on a periodic basis as stated in the contract. If desired, all patient identifying data may be redacted and a case identification number can be substituted.

Medical travel case management programs also vary in how they identify cases, who acts as case manager, with whom the case manager collaborates and coordinates, case manager competency for medical travel coordination, and the level of engagement case managers have with patients and providers. The differences among case management programs undoubtedly have important implications for the impact and effectiveness of medical travel case management and cost containment while ensuring value-based care is delivered.

How Cases Are Identified and Screened

The medical travel case management process may be activated in several different ways. In many instances, the case manager is notified of a potential case by an employer, plan participant, TPA, reinsurer, provider or the TPA's case manager assigned for local in-network routine and elective care who is aware of the program and knows a patient who may benefit from it.

In such situations, the case manager is likely to become involved early when the opportunities are greater for influencing the course of treatment to avoid needless expense. For these reasons, medical travel case management organizations may work with the employer, labor union or other group health services purchaser to increase employees' awareness of the program and encourage early contact.

Generally, the employer and medical travel program developer specify a set of target diagnoses such as knee, hip, spine, shoulder, cardiac, or other conditions that require surgery. These patients are flagged by reviewers or computer software alerts.

The lists of target diagnoses may overlap but are not identical across different companies. For this reason, SurgeryShopper builds each client's program based on the review of past claims expense and utilization data, predictive population health management information and assessment of lifestyle, occupation, and age and gender. Certain diagnostic testing claims with an array of diagnoses reported or repeated prescription fills of pain and/or anti-inflammatory or other medications, or pre-certification and pre-authorization program calls may also serve as flags. Overall, preadmission review and admission review may be of limited use, because many patients with catastrophic illnesses or injuries are admitted on an emergency basis and the prognosis may be highly uncertain for several days.

Once it is determined that the patient is stable and could be safely transported by commercial conveyance or private automobile, the case assessment can be made to determine if medical travel is a safe and more cost efficient option for the patient and the plan. Medical travel case management competencies are different than that which is available from most prior review nurses' skill sets. Specialized training in altitude physiology, medical travel air and destination coordination, and other skill sets is required. BEWARE of "CERTIFIED MEDICAL TRAVEL FACILITATORS". There are many certifying bodies that are merely seminar and workshop sellers who will "certify" laypersons willing to pay $2000-$3000 for a two- or three-day workshop and provide the attendee a few letters after their name and a "badge" of sorts to place on marketing and advertising collateral. The certifiers themselves are not certified by any accrediting body and you'll have no assurance that your plan participants' case management will be appropriate or complete.

Potential medical travel cases may also be identified through the claims administration process. Claims may be screened for target diagnoses; for cumulative allowable payments beyond a certain threshold, for example, $15,000; or for certain patterns of care. By the time a medical travel case is identified from claims for payment, several months of care may already have been provided and chances to initiate less costly care missed. One way SurgeryShopper uses retrospective analysis of claims is to identify missed opportunities and additions, or modifications to existing cost containment programs may be useful in improving the medical travel program by suggesting where opportunities are being overlooked.

To avoid inefficient use of case management resources, the first step is a review of basic demographic, clinical, and claims information. Cases with a reasonable potential for medical travel cost containment are then subject to a more intensive review, including direct communication with the patient and family.

Medical travel case managers make judgments about what cases to accept. They vary in how they make their decisions. These variations relate either to client objectives and concerns or to vendor capacities and strategies and compensation streams.

SurgeryShopper bases decisions in clinical appropriateness, medical travel appropriateness, and its client's cost containment and benefits objectives. We tend to reject cases with no or little potential for savings.

We may reject cases with complications we believe we are unable to handle. We coordinate surgery cases but we sometimes also coordinate sleep studies, and second opinion reviews and consultations.

Some clients decide to start with a pilot program and negotiation of per-case bundled payments to hospitals and ASCs, but may find they need to address an unplanned or unusual case, perhaps one that requires exceptions to benefit plan limitations to make more cost-effective care feasible. These sorts of decision rules may or may not be codified in internal procedure manuals and contracts with clients.

When you work with SurgeryShopper, one call is all it takes to manage the exception. We coordinate with the provider to obtain a cae review and acceptance, bundled price quote, and help them prepare a Memorandum of Understanding to address the exception that may not be provided for in their contract. Typically, the MOU has an expiration date by which the parties can take time to agree and modify or amend the Provider Agreement to reflect the additional procedure and price, after the patient's immediate needs are addressed.

How Case Managers Relate to Patients and Providers

Most medical travel case management programs report that they work with all interested parties—the patient and family, the doctor, the admission and discharge planners at the facility, hotels, home care agencies, and others.

The emphasis placed on patient and family concurrence with medical travelcare coordination varies by group health plan administrator. If an employer group is covered through an HMO, the HMO may be more directive, perhaps insisting on a choice between termination of coverage for services outside the treatment plan or agreement to follow the plan directives. This could give rise to plan benefit dissatisfaction, and worse, compliants to the IRS or US Department of Labor lodged against the employer, rather than the HMO. In the HMO setting, case management may be invisible to the patient because it occurs when the physician calls for approval for hospitalization or use of out-of-plan facilities or services. The take-it-or-leave-it approach was far better tolerated and more prevalent in the 1980s-1990s. Today, this approach has many ERISA implications and increases plan fiduciary risk.

One other consideration is if your organization decides to move Medicare-aged retirees to a Medicare Advantage plan, supplemented by self-funded trust dollars for services available to all other plan participants that are not covered by the Medicare Advantage plan. Medical travel programs that refer patients outside the USA and its territories will have zero coverage by the Medicare Advantage plan. In that case, 100% of the medical travel program expense for that episode of care will be paid for by the trust, and only local pre-operative and post-operative services back home would be covered by the Medicare Advantage plan.

Currently, most medical travel programs offered by employers, unions or insurers use a voluntary approach. Recently, Walmart announced a mandatory program for elective spine surgery cases. There are no reported statistics on patients who refuse case management. SurgeryShopper conducts follow-up surveys of patients and families who have been involved in the process; most others do not.

Professional medical travel case managers at SurgeryShopper seek the cooperation of attending physicians. This is because the attending hometown physicians have essential information about the patient and the course of treatment, can influence patients' and families' acceptance of case management recommendations, and can assist in implementing recommendations by approving medical travel options, participating in hand off activities and physician-to-physician communications, abd ordering or providing necessary medical and diagnostic services, or participating in hand off communications for continuity of aftercare and supervising the

care provided by others when the patient returns to their local home town.

Professional medical travel case managers use written forms, specific criteria and standards, require site reviews, and ongoing provider education forums. Most other firms don't offer this due to the expense involved particularly when it involves travel. SurgeryShopper uses the proceeds from its on-site advertising and a portion of the case management fees to fund ongoing network development, management, maintenance and patient portals and platform operations by trained concierge team member specialists with clinical, travel and destination management competencies.

Rather than subcontracting relations with home health care agencies, nursing homes, rehabilitation centers, durable medical equipment suppliers, and other institutions, we admit providers who bundled these services into their case prices for destination care and assume that local in-network suppliers will provide other such services rendered in the patients' home area. Those providers actually contract directly with the plan sponsor, and not SurgeryShopper. This is also different from all the other medical travel network business models who charge network access fees and per-employee-per-month fees. We view inclusion in the contracting process as a privilege and not as a revenue generation opportunity. We participate because it produces a better outcome for all concerned. When you do the right thing, the money follows naturally.

Most provider contracts offer extraordinary discounted prices for bundled surgery case rates negotiated in advance so that reference-based pricing attempts are not necessary or invited. To access these bundled price savings, however, accelerated payment schedules and pre-authorization guarantees are often required. Contracts directly with providers are often simpler and more straightfoward than the typical managed care plan arrangements in local network Provider Agreements.

How Much Case Management Costs

Another variable factor with medical travel case management programs is their cost. In this example, cost is defined as the price the purchaser of the service pays. Some networks do not explicitly charge for case management services but have embedded the cost as part of their administrative services charge, embedded opaquely as the fee for the surgery, or transparently as a separate line item on a PEPM or per case fee.

SurgeryShopper has set a flat charge per assigned case, carved out from other TPA and general, local network, utilization management services. Most commonly, programs bill on a flat-fee or hourly basis for assessment, coordination, and other services. Hourly charges of $65 to $250 or more have been reported, with charges tending to fall toward the higher end of this range. SurgeryShopper has been established long enough to comfortably predict and charge a flat fee per case to compensate for our time and expertise in coordinating care, travel, measuring outcomes and summarizing savings, value, and patient satisfaction into written reports.

Impact of High-Cost Case Management

There seems to be general acceptance that a medical travel program with effective case management can save money and improve the quality of care and the quality of life for patients and families. Programs that simply treat the matter as appointment scheduling and airline ticketing and hotel reservations are often poorly rated with low satisfaction, high risks for complication and frustration, and minimal value-based savings. Results vary depending on a number of factors—the nature of the patient's problem, the family circumstances, waiver of copayment and deductibles, travel costs paid by the program instead of reimbursed, destination expense allowances paid on a per diem basis instead of reimbursed, physician and hospital cooperation, bundled

rate composition, local community health resources, employer objectives, and sophistication of the case management program. Only recently are systematic data collection and evidence available to support any specific conclusions about the effects of medical travel cost containment and the impact of medical travel case management services. In the example below, SurgeryShopper reporting attempts to summarize the impact and savings of its services and program utilization.

Typical Case Management Summary and Analysis

CONFIDENTIAL CASE REPORT 1		
Patient: YYYY	Client: XXXX	
Referred by: VVVV		
Prepared by: WWWW		
Diagnosis: Degerative arthritis, hip	Date Opened: 2/14/18	Date closed: 7/9/18
INITIAL CASE SUMMARY		
Patient is a 56-year-old woman with degernative arthritis of the left hip. Non-steroidal pain medications and physical therapy have been ineffective. Hip replacement surgery has been recommended by both primary care and orthopedic surgeon within a month of this referral. Referral to the medical travel program was received for assessment and case management if appropriate.		
OUTCOME		
Patient's case was assessed within three working days of referral, decision to travel was made and authorized by the employer's health benefit plan administrator, travel was arranged, coordinated and surgery was performed. The patient was accommodated in a hotel with support from registered nurse and home health aides. Travel home was arranged according with surgeon's Fit-to-Fly / Fit-to-Drive instructions. Upon arrival home, the patient was seen by a hometown provider with two working days of arrival. Physical therapy was continued by home program and rehabilitation and medication adherence apps. Patient outcomes were monitored, measured and recorded by telephone interview with outcomes concierge team staff using modified SF-36. a patient-reported survey of patient health along with patient satisfaction scoring tool similar to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) used in most hospitals.		
COST ANALYSIS ASSUMPTIONS		
Patient would have required more costly local or regional hospitalization at in-network prices, delay due to scarcity of care and in-network specialists in the local area.		
Case management permitted alternative to local and regional in-network costs		
Hospital days averted: 3-5 days		
Local, in-network surgery costs averted: $23,000		
Case management fee: $700	Travel costs: $1600	Program incentive cost: $1500
SAVINGS		
Surgery case costs averted	$23,000	
Travel expenses	($1600)	
Case management fee	($700)	
NET SAVINGS	**$19,200**	

The tools used for outcomes and satisfaction reporting

HCAHPS surveys, conducted at leading healthcare organizations annually since 1995, are available in the public domain and focus on healthcare quality aspects that patients find important and are well equipped to assess. SurgeryShopper adapted this tool for relevance in both the hospital and outpatient day surgery use cases.

RAND SF-36 The Short Form (36) Health Survey is a 36-item, patient-reported survey of patient health. The original SF-36 stemmed from the Medical Outcome Study, MOS, which was conducted by the RAND Corporation. Since then a group of researchers from the original study released a commercial version of SF-36 while the original SF-36 is available in public domain license free from RAND. SurgeryShopper has adapted the public domain version of the SF-36 for use as a baseline measurement prior to surgery and then at incremental measurement points post-operatively to plot and record patient feedback on maximum medical improvement over time.

Direct with Provider Contracting

Fed up with poorly-negotiated in-network hospital prices, an increasing number of employers are cutting out insurance middlemen and engaging in what is known as "direct contracting" with medical providers. They cut their own deals. At SurgeryShopper, we support and assist with this.

According to Rand Corp. direct contracting is a hot topic among employers because they are frustrated with TPAs and PPOs or ASOs not keeping prices in check. But direct contracting won't work equally well everywhere. Employers in urban areas where single providers or provider brands lack significant market share, but it could work in rural areas where there is a dominant employer or some other large group. The most difficult and challenging first hurdle to overcome is access to price data. Many TPAs and brokers promise to share data from fancy platforms. The platforms produce the data desired, but the TPAs and ASOs and PPOs or brokers won't share the level of granularity an employer needs to make determinations if rates are reasonable.

"Imagine that your TPA, PPO, or ASO has negotiated rates that include embedded extra commissions and silent kickbacks that are a percentage of revenue while you pay them to be your advocate for lower prices," said Maria Todd, an expert in ERISA plan cost containment strategies and medical travel. Would you want the client to see that you've been double- or triple-dipping into their trust account? So while these middle layered entities promise the sun, the moon and the stars in their nondescript references to "reporting" you'll get, the data is rarely actionable or adequately informative to enable the employer to shop independently and know where to find and how to negotiate and what numbers to target for better prices. That's where Todd comes in. She has no dog in the race. She works as an independent consultant on a fee-for-service basis with employers who want to keep brokers, TPAs, PPOs and ASOs "honest".

Todd asks the difficult questions - the ones that the brokers, TPAs, PPOs and ASOs who pay lip service to transparency and reporting practices hate to be put on the spot for. She asks them to put their sample reports on the table. Then she calls them out on holding back the "essential data" they need that's actionable.

The owner of the data has power. But the power doesn't benefit the employer or its plan participants unless the data is analyzed, understood and available for review. Many employers lack this competency and their brokers aren't volunteering to help as much as they could because it isn't in their own best interests. Todd comes in

as the time saver. She realized that employers don't know what to ask, how to analyze and what data is really being held back. They also have busy days with what's already on their plate and have no time to learn. So Todd engages as their independent expert.

Todd brings expertise gained over 40 years of contracting on behalf of both the health plans and the providers. She knows where to look, what to ask, what data is available that's not being shared, and how much healthcare costs, nationwide, especially when it comes to bundled prices for surgery. She's also owned and operated a TPA and worked for HMOs and PPOs in the past. In addition, she leverages a rare additional skill and insight most consultants lack: She's a former OR nurse and a former hospital and ASC administrator. She leverages these insights to be a formidable force at the table when engaged by employers seeking to deal directly with providers and skip the intermediaries. She knows how to get the providers to sharpen their pencils. When it comes to building medical travel programs for surgical carve outs and cost containment, she has no equal in the industry.

In some communities, where there is only one provider, she's identified rates that are 550% of Medicare and as high as 850% of Medicare. But she is no fan of reference-based pricing because it isn't fair or honest to knock on the door of the provider after the procedures or services have been performed to insist on price reductions to 130% of Medicare without a contract or the value of steerage and frequency. "Most providers are trending towards telling reference-based pricing negotiators to take a hike" says Todd. They are not duty bound to accept the RBP offers. There is a rising trend to accept the discounted rate from the employer and then balance bill the patient. Todd estimates that RBP will be a short-term market approach to cost containment that will be no more than a blip on the timeline of cost containment solutions tried within about two years. Providers should not hang their hat on this method.

Once charges and negotiated prices to in-network providers are known and understood, the next step is to find willing providers who invite direct-with-employer contracts. SurgeryShopper acts as the conduit between the employer and the provider. Its experts facilitate the direct contract under Todd's direction, when invited to do so.

- They have the model SPD language to make modification simple and quick. It is often no more than a few paragraphs that address how the travel will be paid for since the coverage for surgical procedures are already addressed elsewhere in the SPD. In fact, many SPDs already include similar language for transplant network services and associated medical travel coverage.
- They supply model contract templates that can be used for the direct-deal between employer and provider. Attorney review is always recommended, but the parties won't have to wait will the attorney figures out what to draft as an offer and form Agreement.
- They supply the templates that can be used for plan participant education, pre-authorization and pre-certification forms, examples of bundled claims so that the TPA or ASO will know exactly how the bill will arrive.
- SurgeryShopper has the platform up and running to manage all the care and travel coordination, case management, and can easily set up the platform access as a portal that has been tested, is secure, and ready to facilitate all aspects of patient movement and records exchange, outcomes measurement and cost/value reporting. Todd helped develop and test the software years ago. In its current iteration, a patient application is now pending. She disclaims that she is an equity shareholder in the software.

There are a number of "conduit" providers popping up all over the USA. The difference is they all charge a fee to find the providers. SurgeryShopper doesn't charge these fees. When an employer is paying upwards of $72 per

employee per year (PEPY) just to learn who wants to talk with them, SurgeryShopper has a huge competitive advantage.

Sample Project Scope

Overview
1. Project Background and Description

[NAME] is a self-funded employer headquartered in [STATE] with 452 employees located in [LOCATION(s)]. The employer operates a self-funded health benefits plan regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and possible also the Taft Hartley Act of 1947 that regulates negotiated benefits for self-funded union health and welfare benefit plans.

Recently, {name} has been reviewing benefit programs, broker relationships, TPA relationships and network services available to plan participants through TPA-, ASO- and PPO-negotiated contracts with providers. Without access to data, information about price transparency, and percentage commissions and kickbacks embedded into rates paid for medical and dental services and pharmacy products, it suspects that it might do better with direct with provider contracts that would eliminate or reduce the embedded fees, administrative charges, kickbacks and referral and steerage commissions that are ultimately paid by the employer's claim trust account and plan participants in the form of deductibles and copayments.

As a part of this review, they have encountered a trend in surgical services carve outs as a means of cost containment. Whether local or in another city, surgical carve out programs provide an alternative option to obtain surgical services, in- or out-of-network with designated services providers at rates that are often significantly lower than the employer's in-network negotiated rates.

Providers are willing to negotiate directly with employers using form Agreements that set out accelerated payment terms and conditions to access the provider's bundled price services using a single-line item invoice that is billed at exactly the prices negotiated.

The employer saves money by reducing the number of payments sent out by the TPA, and by eliminating the time and cost of repricing each claim from each individual provider (surgeon, anesthesiologist, assistant surgeon, facility fees, supplies, technology, implants and prosthetics, high cost medications used during surgery, and separate charges for operating theatre, pre-operative fees and post-operative recovery room charges, and surgeon discharge evaluation and management fees.

The providers also see value in these arrangements because they are paid more accurately and sooner than in their typical managed care agreements. There is less financial risk, especially when the provider has a good grasp of its costs for labor, supplies, implants and prosthetics, and is paid on the date of service instead of waiting to be paid for sometimes as long as six months in arears.

The surgeons and anesthesiologists also extend lower rates because they enjoy the same pre-authorization as the bundler of record in that they don't have to endure the cost to have staffers obtain pre-authorization that would be redundant and don't have to absorb between 28-32% of revenue as a cost to collect what is owed. If the bundler of record was paid on the date of service via check, pre-loaded debit card, or ACH, the surgeon simply changes into street clothes after the procedure and walks away with a check in hand for services rendered.

Most surgery centers and hospitals are accredited by one of several generally-recognized accrediting bodies which, during its triennial or biennial surveys reviews the policies, procedures, documentation and criteria for granting privileges at the facility. This review is more in depth than an employer could manage without spending significant sums on experts who could independently verify the credentialing and privileging practices, standards and documentation of surgeons, anesthesiologists, radiologists, pathologists and nurses who are involved in the program rendering direct patient care.

Reliance on the primary source verification with assigned risk for errors and omissions within the direct-with-provider contract can result in a savings of ten thousand ($10,000) dollars (or more) with an independent consultant to repeat the verification and review performed by the accrediting bodies to no real quality of safety gain. It also allows the parties to move forward more quickly into the business of saving money on surgical services.

Medical travel, an associated concept with a surgical carve out, is the way that a participant gets from their hometown to the destination where the savings are available. Medical travel requires unique competencies related to: a) patient movement, b) altitude physiology to mitigate the risks of wound disruption and the risk of blood clots that could be life-threatening; c) choosing appropriate accommodations and ground support services such as home health nurses and aides that may visit the post-operative patient at the hotel, and pre-screening drivers and car services to ensure that the vehicles used are appropriate for non-emergency, scheduled patient transfers. Medical travel expertise includes knowing about the aircraft design, seating arrangements, wound disruption risks, airport transfers, special diet requirements for in-flight meals and snacks, what to do if the patient misconnects at a hub airport, or needs to change return flight plans for medical reasons.

Medical travel itself is not the cost containment mechanism. It is merely the means by which the cost containment benefits of a surgical carve out program may be activated. In some cases, the employer is able to negotiate direct-with-employer contracts that don't require travel to another destination.

Therefore the nature of this project is not specifically to set up medical travel as much as it is to design a surgical carve out benefit that facilitates cost containment but also addresses the need to arrange and coordinate medical travel if the destination where the savings are is not local or within a reasonable drive or public transportation access range.

2. Project Scope

Development of a surgical carve out benefit.

The employer seeks the assistance of an independent expert with competency to guide the employer through the process of surgical carve out benefit design.

The employer shall obtain data at a level of specificity requested by the expert about past claims expense history, population demographics, and other data that may be necessary to design a custom-tailored surgical carve out benefit program that addresses key spending categories that have been higher than necessary or spending categories that will be high, supported by predictive modeling output reports.

The program infrastructure shall include various "triggers" that signal that a savings opportunity may be available. These triggers can include, among others, claims submissions for lab and pathology tests and imaging procedures with diagnoses for which surgery is anticipated, primary care referrals, surgical pre-authorizations and pre-certifications, pharmacy data, case manager referrals, and more.

The program must have a means by which all triggers can be collected and referred to a program facilitator or coordinator who evaluates the case for appropriateness. If appropriate, the next steps are taken to obtain

patient, employer, provider and family agreement that the surgical carve-out program will be used in lieu of in-network services under the PPO or HMO network available locally.

The program ushers the plan participant and companion traveler through the process through the post-operative period and for a short-tail period during which outcomes are measured and recorded.

The program is completed by developing a means to communicate savings and outcomes achieved through the use of the program. It also designs the means by which program modifications are evaluated by necessity or how urgent additions are carried out "on-the-fly", how new procedures are contracted, how providers are paid, and which procedures are included in the initial pilot program or as the life-cycle of the program continues.

The goal of the engagement with the consultant is that the program, if designed correctly is a one-time engagement for a predictable and transparent fee for the consultant's services that requires little, if any, ongoing consultant involvement once the program deliverable has been accepted and tested to work as expected. The employer should be able to manage program modifications and expansions independently, and only call on the consultant in rare instances to address designated carve out network expansion, advice in contract modifications as the employer's advocate from time to time.

3. High-level Requirements

The consultant must have

- At least 15 years of experience in working with insurance, medical services contracting, ERISA and Taft Hartley benefits management and procurement;
- An advanced, in-depth understanding of the difference between self-funded and fully-insured health benefit arrangements, managed care networks, and in-network and out-of-network points of access;
- Complete familiarity with how employers procure benefits and healthcare provider services – more specifically surgical services, through brokers, agents, TPAs, ASOs and PPOs;
- A deep understanding and appreciation for the employers' plan administrator fiduciary requirements and compliance options;
- Familiarity with data sources and reporting related to claims expenditures, triggers for case management services and ways to identify cost containment opportunities. The optimal candidate will have payer-side professional work experience and an understanding of what data may be available through TPAs and ASOs that are not routinely shared but often available upon specific request;
- Knowledge of surgical procedures, anatomy, physiology and medical terminology, clinical care coordination and case management;
- Familiarity with the norms, problems and pain points of healthcare provider revenue cycle operations, objectives, and be able to guide the employer to design a draft form agreement for use as the contract between employer and provider, that would be acceptable to a provider, compliant with state and federal laws and regulations, and more easily administrated than current managed care contract agreements;
- Familiarity with regional pricing of surgical case rates for distinct episodes of care by CPT and HCPCS codes in both hospital and ASC setting;
- Thorough understanding of the leading and nationally-recognized health facilities accreditation, standards of care, quality and safety documentation and best practices, and operations

- A firm understanding of all the elements of bundled surgery case rates for an episode of care.
- Knowledge of U.S. geography, airport operations, and interstate travel systems,
- An advanced working knowledge of medical travel program design adequate to guide the employer to develop a program that includes detailed coordination of medical travel operations involving many people, facilities, or services, supplies, and travel and accommodation selection criteria for medical recovery accommodations, negotiation of discounts, and the travel ticketing, tariff and booking and reservation changes rules; and
- Understanding of altitude physiology and travel physiology to mitigate travel-associated risks of medical complications. The ideal candidate will have actual hands-on clinical case management experience and know how to integrate resources across medical and travel continuums.

4. Deliverables

A complete working model and prototype for a surgical carve out cost containment program and medical travel program.

Including, but not limited to:

1. Written surgical carve out cost containment program selection criteria (which cases, which circumstances for a pilot program of 15 key surgery procedures that the employer should implement first.)
2. Written surgical provider and facility selection criteria
3. Draft contract form agreement(s) between employer and provider ready for attorney review
4. Draft language for SPD modification to address travel reimbursement
5. Draft written program guide and user handbook(s) for plan participant and administrator education
6. Draft program guide for TPA education and execution
7. Sample report formats and layouts that would be beneficial to inform plan administrators of savings and clinical outcomes, value, and other metrics and key performance indicators of the program

5. Specific Exclusions from Scope

1. Facilitating or mediating the contracting process with providers (addressed under a separate project scope or engagement)
2. Identifying, pre-qualifying, and short listing specific providers willing to contract with Employer (can be addressed with the assistance of SurgeryShopper client services representatives or through other channels)
3. Live presentations to employees on how and when to best benefit from the use of the surgical carve out program benefit.
4. Installation of a service portal to be used by plan participants and other authorized parties.

6. Implementation Plan

1. Consultant shall review the plan SPD and enrollment demographics
2. Consultant shall specify data to be supplied by the employer gathered from the TPA, reinsurer, or other plan population health data sources and claims experience. Employer shall tender all requested data to consultant via email for analysis.
3. Consultant shall perform remote analysis to identify most advantageous procedures for a pilot program recommendation for the first 15 procedures or surgical procedure categories to initiate the program.
4. Consultant shall supply SPD modification data for review by employer's competent counsel (legal, benefits, compliance, underwriting, reinsurance, accounting, administration, union representatives and executives).
5. Once the SPD modification has been approved candidate providers will be approached with the opportunity to negotiate for the employer's business. If terms are agreed, the draft form agreement will be submitted to employer's counsel of stakeholder reviewers. Upon approval of the document, it will be sent to providers for signature execution.
6. Consultant will work with the TPA to implement workflows once a case is triggered for review and approval. Consultant will serve as project manager for the employer to work with the team members from the TPA to create, test and implement programmatic workflows to approve a case, forward to assigned case managers who may be external of the TPA, through final provider settlement.
7. Consultant will work with plan administrator to develop the workflows for program outcomes review, savings summary and other reports.
8. Consultant will work with as the project manager to collaborate with case managers for their role in the process.
9. Consultant will work with the providers to test their readiness to receive patients and move them through the surgical episode of care. Consultant shall participate in a "dry run" before the first patient or alternatively, accompany the first patient as the representative of the employer.
10. Consultant will monitor and review first patient reported outcomes and results, impressions, and satisfaction levels. Consultant will also elicit feedback from the TPA and the provider and case managers.
11. Once the program has been deemed "implemented", the consultant will sign off and remain "on call" and available if employer has questions, concerns or an unexpected situation arises for which the advice from the consultant adds value.

7. High-Level Timeline/Schedule

Typically this project can be developed, implemented and tested and go live within 90-120 days. The highest risk of delay resides with the employer and its ability to supply the required data for the analysis in Step 6.3 above.

Sample Surgery Prices

Bundled case surgery prices that can be had without PEPM network fees or broker commissions, in the USA.

Bundled pricing includes the following:

- ASC/Surgical Center Fees—Operating Room and Recovery Areas
- Physician/Surgeon's Fees
- Anesthesia Fees
- Standard Implants and Hardware
- Overnight Stay (up to 23-hour Overnight/Extended Stay for certain procedures)

The initial consultation and/or pre-operative visit with the surgeon is included, as is uncomplicated follow up care. The duration of post-operative care varies depending on the surgical procedure as well as the surgeon. The surgeon will inform you at the initial consultation the amount of projected post-operative care that will be needed and covered by the price.

Some physicians require a $150 initial consultation fee. This $150 initial consultation fee is applied to the total cost of the procedure should surgery be completed. If surgery is not completed, the $150.00 will be retained by the surgeon.

SPINE

22551	Anterior Cervical Discectomy with Fusion, 1 level	$16,960
22552	Anterior Cervical Discectomy with Fusion, 2 levels	$22,870
22554	Cervical Spine Fusion (Arthrodesis)	$17,960
22612	Lumbar Spine Fusion (Arthrodesis)	$23,870
22856	Cervical Disc Replacement--One Level	$18,990
22858	Cervical Disc Replacement--Two Levels	$24,950
63020	Cervical Discectomy (Neck Spine Disc Surgery)	$8,995
63030	Lumbar Discectomy (Low Back Spine Disc Surgery)	$9,945
63042	Lumbar Laminotomy	$8,985
63045	Cervical Laminectomy--Open	$7,995
63046	Thoracic Laminectomy--Open	$7,995
63047	Lumbar Laminectomy--Open	$8,495
63055	Spinal Cord Decompression (Thoracic)	$7,995
63056	Spinal Cord Decompression (Lumbar)	$7,995
63030	Microdiscectomy	$7,445

PAIN

62310	Cervical Epidural Steroid Injection	$1,150
62275	Epidural Blood Patch	$990
62311	Lumbar Epidural Steroid Injection	$790
62311	Lumbar Epidural Steroid Injection (w/ sedation)	$990
64520	Lumbar Sympathetic	$1,395
64415	Re-block for Acute Postop Pain	$725
64510	Stellate Ganglion Block	$890

SHOULDER

23455 / 29806	Bankart Repair (Open / Arthroscopic)	$5,985
29824 / 23120	Distal Clavicle Excision (Mumford, Arthroscopic)	$5,215
29823	Extensive Debridement, Shoulder (Arthroscopic)	$5,345
23410 / 23412	Open Rotator Cuff Repair (Acute / Chronic)	$6,125
24341	Pectoralis Muscle Rupture Repair	$5,450
29827	Rotator Cuff Repair (Arthroscopic)	$7,795
29805	Shoulder Arthroscopy	$4,985
23700	Shoulder Manipulation (with Anesthesia)	$1,885
23472	Shoulder Replacement--Total	$16,985
23472	Shoulder Replacement--Reverse	$18,995
29826	Subacromial Decompression (Arthroscopic)	$5,485
29807	SLAP Repair (Sup. Labrum Ant. & Post., Arthroscopic)	$6,955

HIP

29862 / 29863	Hip Arthroscopy, Complex--(Debridement / Synovectomy)	$8,485
29861	Hip Arthroscopy, Simple (diagnostic/removal of foreign body)	$4,995
27130	Hip Replacement (Arthroplasty)	$17,985

KNEE

29888	Anterior Cruciate Ligament (ACL) Reconstruction (Autograft)	$6,335
29888 / 27427	Anterior Cruciate Ligament (ACL) Reconstruction with Allograft (Arthroscopic / Open)	$8,935
29877	Chondroplasty (Cartilage Debridement, Arthroscopic)	$3,735
29870, 29871	Knee Arthroscopy (Both)	$4,985
29870, 29871	Knee Arthoscopy (One)	$3,735
29882, 29883	Knee Arthroscopy with Meniscal Repair (Arthroscopic)	$4,985
27446	Knee Replacement--Oxford (Partial Knee)	$15,985
27447	Knee Replacement--Total	$14,990
29873	Knee with Lateral Release or Microfracture (Arthroscopic)	$3,995
29880, 29881	Medial & Lateral Meniscectomy (Arthroscopic)	$3,995
27405	Medial Collateral Ligament (MCL) Reconstruction	$5,785
27422	Medial Patellofemoral Ligament (MPFL) Reconst.--with Allograft	$7,950
27420, 27422	Medial Patellofemoral Ligament (MPFL) Repair	$5,450
27409	Posterior Cruciate Ligament (PCL) Reconstruction	$6,985
29876	Synovectomy--Complete (Arthroscopic)	$3,735
27455	Tibial Tubercle Osteotomy	$5,865

ARM/ELBOW

23430	Bicep/Tricep Repair--Tendon or Muscle, (Exc. Rotator Cuff)	$4,585
15836	Brachioplasty (Tighten Arm Skin)	$5,905
24105	Bursectomy (Elbow)	$2,650
64718	Cubital Tunnel Release	$2,875
24342	Distal Biceps Re-attachment	$5,385
29830	Elbow Arthoscopy	$3,735
24300	Elbow Manipulation (under Anesthesia)	$1,900
24363	Total Elbow Arthroplasty (Replacement)	$11,285
64718, 24358	Ulnar Nerve Release / Epicondylectomy	$3,975

HARDWARE REMOVAL

20680 Complex (Deep) $3,995
20670 Simple (Superficial) $2,495

FRACTURES

25605 Closed Reduction and Casting $1,780
23615 Complex Fracture- (Rod of Humerus, Tibia, or Femur) $6,205
26727 Percutaneous Pinning – Finger 1-2 Pins $2,625
23600 Simple Fracture Requiring Open Reduction $4,485

HAND & WRIST

24721 Carpal Tunnel Release (Open) $2,790
29848 Carpal Tunnel Release--Arthroscopic $2,790
25606, 25607 Distal Radius Fracture Repair $7,745
26040, 26045 Dupuytrens Contracture (Release) $2,950
26160 Excision of Lesion of Tendon Sheath or Joint Capsule (e.g. Cyst, Mucous Cyst, or Ganglion) $2,265
26123 Fasciectomy, Partial Palmar with Release of Single Digit including Proximal Interphalangeal Joint, with or without Z-plasty, other Local Tissue Rearrangement, or Skin Grafting $5,990
25111 Ganglion Excision $2,725
25447 Suspensionplasty, Arthroplasty, Interposition, Intercarpal or Carpometacarpal Joints $4,495
26145 Synovectomy, Tendon Sheath, Radical (Tenosynovectomy), Flexor Tendon, Palm and/or Finger, Each Tendon $2,950
26055 Trigger Finger Repair $2,475
25445, 25447 Thumb Arthroplasty $4,250
25440 Wrist Revision / Reconstruction (Open Reduction, Internal Fixation of Scaphoid non-union with Local Bone Graft $4,750
29840, 29846 Wrist Arthroscopy $3,995
25332 Wrist Replacement $10,795

FOOT & ANKLE

27650 Achilles Tendon Repair $4,995
29891, 29898 Ankle Arthroscopy $3,735
28750 Big Toe Repair (Metatarsophalangeal Joint Fusion) $3,955
28108, 28120 Bone Spur Removal--Toe $1,985
27695, 27696 Brostrom Procedure (Ligament Reconstruction) $5,865
28290, 28292, 29296 Bunionectomy--Both Sides $5,815
28290, 28292, 28296 Bunionectomy--One Side $3,915
28285 Hammertoe Correction (1 Toe) $2,395
28285 Hammertoe Correction (2 Toes) $2,950
28285 Hammertoe Correction (3 Toes) $3,565
28119 Heel Spur Removal $3,450
28080 Neuroma Excision--Intermetatarsal $2,605
28060 Plantar Fasciotomy (Heel Pain Treatment) $3,325
28035 Tarsal Tunnel Release $2,825
28308 Tailor's Bunion Removal $2,875

UROLOGY

57240 Anterior Colporrhaphy Repair (Cystocele Repair) $5,890
57288 Bladder Repair (for Incontinence) $5,455
52234 Bladder Tumor Removal $4,860
54160 Circumcision $1,800
52332 Cystoscopy for Stone / Stent Placement $3,225
52351 Cystoscopy with Pyelography $1,945
54860 Epididymectomy – Partial $3,455
54860 Epididymectomy – Total $4,065
55040 Hydrocelectomy $3,495
57288 Mini-Arc Urethral Suspension $4,415
57250 Posterior Repair (Rectocele)--With Mesh $5,895
54500 Testicular Biopsy $1,800
52234 Transurethral Resection, Bladder Tumor $2,490
52601 Transurethral Resection, Prostrate $3,490
55400 Vasovasostomy (Vasectomy Reversal) $5,585

GASTRO-INTESTINAL

45378 Colonoscopy $1,250 (plus pathology fees, if required)
43235 Endoscopy--Esophogeal/Gastric/Duodenal (EGD) $1,350

EAR

69420, 69421 Bilateral Myringotomy with Tubes (BMT) $1,595
69436 Ear Tube Placement (Tympanostomy) $1,595
69200 Foreign Body Removal $1,350
69660 Inner Ear – Stapedectomy $4,895
69715 Mastoidectomy--Simple $5,985
69620 Myringoplasty (Perforated Eardrum Repair) $2,450
69661 Ossiculoplasty (Middle Earbone Repair) $4,735
69300 Otoplasty (Repair Protruding Ears) $3,435
69645 Tympanoplasty--Complex (Ear Drum Reconstruction) $4,965
69641 Tympanoplasty with Mastoidectomy--Simple $8,780

NOSE/SINUS

31255 + 30802 Complex Sinus Procedure, Bilateral w. Turbinates Reduction $6,985
21325 Nasal Fracture Complex Open $3,620
21310 Nasal Fracture Simple Closed $1,715
21320 Nasal Fracture w/ Stabilization $1,715
30410 Rhinoplasty (Nose Job) $4,745
30520 Septoplasty (Nasal Septum Repair) $3,495
30520 + 30140 Septoplasty and Sinus / Turbinates Reduction $4,685
30850 Sinus / Turbinates Reduction--Both Sides $4,365
30150 Submucosal Resection of Turbinates $2,480

THROAT

42830 Adenoid Removal (Adenoidectomy) $2,545
72830 69436 Adenoidectomy with BMT $2,995

43200 Esophagoscopy (with or without Dialation/Biopsy) $1,950
40819 Frenulectomy (Repair Tongue Tie) $1,500
31525 Laryngoscopy (with or without Biopsy) $2,450
38510 Lymph Node Excision / Biopsy $2,585
42415 Parotidectomy (Salivary Gland Removal) $7,150
60280 Thyroglossal Duct Cyst Excision $3,465
60210 Thyroidectomy Total or Partial Thyroid Lobectomy, Unilateral; including Isthmusectomy $5,895
60240 Thyroidectomy, Complex $7,845
42825, 42826 Tonsillectomy $2,545
42825 42826 69436 Tonsillectomy with BMT $2,995
42820 42821 Tonsillectomy and Adenoidectomy $2,965
42820 69436 Tonsillectomy & Adenoidectomy with BMT $3,565
42145 UPPP--Uvulopalatopharyngoplasty (Palatoplasty) $5,365

EYES

66174 Ab-Interno Canaloplasty $4,950
0191T Aqueous Drainage Device (iStent) $4,500
66982, 66984 Cataract Surgery--Standard Lens (One Eye) $2,950
66984, 0191T Cataract Surgery & Glaucoma (With iStent)--One Eye $4,900
67800 Chalazion Removal $1,775
65710, 65730 Keratoplasty--Corneal Transplant $9,985
15822, 15823 Droopy Eyelid Revision (Bleph)--Both Upper lids with Ptosis Repair $3,850
15822, 15823 Droopy Eyelid Revision (Blepharoplasty)--Upper (One Side) $2,495
15820, 15822, 15823 Droopy Eyelid Revision (Blepharoplasty)--Upper & Lower (Bilateral) $4,940
67917, 67923 Ectropican/Entropion Repair $4,445
67311 Eye Muscle Surgery, 1 Muscle $2,975
67312 Eye Muscle Surgery, 2 Muscles $3,895
67314, 67316 Eye Muscle Surgery, 3 or more Muscles $4,455
66179 Glaucoma Drainage Device (without Graft) $5,350
66180 Glaucoma Drainage Device (with Graft) $5,900
67041 / 67042 Macular Pucker Repair $4,650
67042 Macular Hole Repair (Includes Gas or Oil) $4,850
68810 Nasolacrimal Duct Probe – Both Sides $3,495
68815 Nasolacrimal Duct Probe – One Side $2,395
65426 Pterigium Excision--w/ Amnionic Membrane $4,400
65426 Pterigium Excision--w/ Autograft $4,100
67036 Pars Plana Vitrectomy $3,955
67113 Repair Detached Retina (Incl. Gas or Oil) $4,950
67121 Silicone Oil Removal--Retina Surgery $2,995
66172 Trabeculectomy Revision (with previous surgery in eye) $5,450
66170 Trabeculectomy (without previous surgery in eye) $4,900
66710 Transcleral Cyclophotocoagulation $4,965

GYNECOLOGY

57240 Anterior Colporrhaphy Repair (Cystocele Repair) $5,670
58600, 58670 Bilateral Tubal Ligation (BTL)--Block or Cut Fallopian Tubes $2,990

57288 Bladder Repair (for Incontinence) $5,455
57520 Cervical Cone Biopsy $2,395
57120 Colpoclesis (Le Fort Technique)--Vaginal Vault Prolapse $3,895
57425 Colpopexy (Vaginal Vault Suspension) $3,425
52000 Cystoscopy $3,490
58120 Dilation and Curettage (D & C) $1,600
58558 D & C with Hysteroscopy $2,695
58563 Endometrial Abalation--Thermal (Novasure) $3,695
57268 Enterocele Repair $3,990
56700 Hymenectomy $1,525
58555 Hysteroscopy $2,295
56620 Labiaplasty $3,975
49320 Laparoscopy--Diagnostic $3,875
58550 58572 Laparoscopically Assisted Vaginal Hysterectomy (LAVH) $7,445
58550 57240/57250 Laparo Hysterectomy w/ Anterior Repair OR Posterior Repair (No Mesh) $7,985
58550 57260 Laparoscopic Hysterectomy with Anterior Repair (Cystocele) AND Posterior Repair (Recto-cele)--(No Mesh) $9,285
58545 Myomectomy--Laparotomy (Remove Uterine Fibroid) $4,985
58661 Ovary Removal (Laparscopic Oopherectomy) $4,965
58662 Ovary Repair--Remove Adhesions, Lesions, Cysts $4,555
57250 Posterior Repair (Rectocele) $5,895
58570 Total Laparoscopic Hysterectomy (TLH) $7,580
57530 Trachelectomy (Cervix Removal) $3,285
58750 Tubal Reanastomosis (Tubal Reversal) $7,995

GENERAL SURGERY
44900 Appendectomy--Laparoscopic $4,255
38500 Auxillary Node Dissection $3,870
38525 Biopsy or Excision Open Deep Axillary Nodes $3,870
36589 Central IV Access Port Removal $1,800
36561 Central IV Acess Port--Install $2,870
47562 47563 Gall Bladder Removal (Laparoscopic Cholecystectomy) $4,995
46250, 46255 Hemorrhoidectomy $3,120
55040 Hydrocelectomy $3,495
49418 Peritoneal Dialysis Catheter Placement $4,315
11770 Pilonidal Cyst Removal $2,980
11400 Sub-Cutaneous Mass Removal $1,850

Open, Laparoscopic HERNIA
49570, 49652 Epigastric Hernia Repair (Add $450.00 for Laparoscopy) $3,150
49560, 49654 Incisional Hernia Repair (Add $450.00 for Laparoscopy) $3,950
49505, 49650 Inguinal Hernia Repair--Single (Add $450.00 for Laparoscopy) $3,050
49505, 49650 Inguinal Hernia Repair--Bilateral (Add $450.00 for Laparoscopy) $4,250
49585, 49652 Umbilical Hernia Repair (Add $450.00 for Laparoscopy) $3,050
49565, 49652 Ventral Hernia Repair (Add $450.00 for Laparoscopy) $3,350

BREAST

19325	Breast Augmentation--Saline	$3,905
19325	Breast Augmentation--Silicon	$5,255
19316	Breast Lift--Mastopexy	$5,580
19342	Breast Reconstruction (1st Stage) With Expanders, Both	$6,985
19342	Breast Reconstruction (1st Stage) with Expanders, Single	$4,915
19357	Breast Reconstruction (2nd Stage) with Implant, Bilateral	$5,855
19357	Breast Reconstruction (2nd Stage) with Implant, Single	$3,985
19318	Breast Reduction--Both Sides	$8,450
19318	Breast Reduction--One Side	$5,580
19300	Gynocomastia (Breast Reduction--Men)	$4,195
19350	Nipple Reconstruction--Both Sides	$4,670
19302	Mastectomy w/ or w/o Node Dissection	$4,490
19120	Removal of Benign Lesion	$1,850
19301	Removal of Benign Mass	$2,195

FACE--COSMETIC/PLASTIC SURGERY

67900	Browlift (Endoscopic)	$4,820
12051	Earlobe Repair (Close Earlobe Holes)	$1,625
15824, 15826	Facelift--(Rhytidectomy)	$7,965
15826	Mini-Face Lift	$6,445
69300	Otoplasty (Fix Protruding Ears)	$3,935
30400	Rhinoplasty (Nose Job)	$4,745

BODY--COSMETIC PLASTIC SURGERY

15836	Brachioplasty (Tighten Arm Skin)	$5,905
15835 + 15877	Brazilian Buttlift (includes one area liposuction)	$7,175
15830	Circumfrential Body Lift	$13,985
15877	Liposuction (Two Areas)	$3,875
15830	Tummy Tuck (Abdominoplasty)	$7,465

A list of what is NOT included in the surgical fee is as follows:

- Any necessary diagnostic studies prior to the surgery such as lab work, MRI, and/or X-rays, or other diagnostic imaging.
- Any unanticipated Lab Fees or Pathology Reports for Biopsies or Tissue samples that are collected during the surgery.
- Consultations with specialists to determine medical risk/management.
- Physical therapy and rehabilitation after the surgery.
- Long-term acute care and rehab care facilities (beyond the 23-hour Overnight/Extended stay that is included in the surgical fee, if medically necessary).
- Lodging and travel expenses.
- Medications for hemophiliac patients
- Expenses or fees resulting from complications subsequent to the completion of surgery and disharge from the facility.
- Private duty nurse or home health aide at hotel.
- Physical therapist visit to hotel, if requested.

Prices valid 3/31/2019 and subject to change without advance notice.