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 we 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.