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How to Start and Build a Practice in Microsurgical Breast Reconstruction: Success and Sustainability in a Private Practice Setting

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Summary: The aim of this article is to provide a template for building and sustaining a microsurgical breast reconstruction practice in a private practice setting. The target audience including residents, microsurgical fellows, and reconstructive microsurgeons were currently employed in an academic setting, and reconstructive microsurgeons were currently employed in a private group entity. We present five pillars that initiate, support, and sustain a successful practice in microsurgical breast reconstruction. The five key concepts are (1) establishing a practice vision and culture, (2) obtaining funding, (3) assembling staff, (4) negotiating insurance and other contracts, and (5) striving for efficiency and sustainability. These concepts have been at the core of Plastic, Reconstructive and Microsurgical Associates of South Texas—a private practice eight-physician group based in San Antonio, Tex.—since its inception. However, these concepts have evolved as the practice has grown and as the economic landscape has changed for reconstructive microsurgeons. In the article, we will present what we have done well, what we could have done better, and some pitfalls to avoid. *(Plast Reconstr Surg Glob Open 2024; 12:e5267; doi: 10.1097/GOX.0000000000005267; Published online 5 February 2024.)*

PILLAR 1: ESTABLISH A VISION AND FORMULATE A CULTURE

The first pillar is to decide why you would like to establish a private practice and to establish a vision of what you would like your practice to be. A summary of pillars 1–5 is established in Table 1. Reasons to start your own practice include greater earning potential than in salaried academic or hospital practices, feeling that you are compensated fairly, greater autonomy than in an employed position, and an opportunity to establish and execute your professional vision.[1–5] Decide which service lines you want. Restriction brings clarity. In our experience, establishing a successful microsurgical breast reconstruction practice requires making this a core service, perhaps the only service, as is the case with our practice. This means that one may need to omit many of the other service lines that plastic surgeons learn during their training. Autologous tissue breast reconstruction, especially with the DIEP flap and its variants, is compelling. The demand is high, with an estimated 297,790 new cases of breast cancer in 2023, an increasing trend for contralateral prophylactic mastectomy, and effective risk reduction with bilateral prophylactic mastectomies.[6–8] Outcomes and patient satisfaction are excellent.[9–15] Some things pair well; some do not. For example, microsurgical breast reconstruction could pair well with cosmetic breast surgery and cosmetic surgery of the trunk. Microsurgical breast reconstruction and, say, hand or microsurgical head and neck reconstructive surgery may not pair well. Consider your community and its physician and general population demographics. Be able to define your vision and to articulate what you want for your practice culture.

From the outset, we at Plastic, Reconstructive and Microsurgical Associates of South Texas (PRMA) were intentional in letting the physician community and the community at large know that we were a practice focused on reconstruction. Initially, we did a wide array of reconstructive microsurgical procedures. Within several years, we narrowed this down to breast reconstruction as the core service, for which we recognized that there was an unmet need in the community. At that time, we did this at the grassroots level, educating surgeons and oncologists in the community about autologous tissue–based breast reconstruction and making it clear that we were committed to serving patients with acquired breast deformities. Do not assume that physicians in your community know about autologous tissue breast reconstruction; misconceptions about the scope of plastic surgery are common.[16]

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One-on-one communication with practitioners, and the community at large, is as important today as it was when we founded PRMA 29 years ago. Word of mouth remains an important, if not the most important, source of information about plastic surgery.[17] However, today's practice branding is dependent on the use of social media platforms.[18] Social media platforms such as Facebook, Twitter, Instagram, and YouTube allow for persistent and seamless messaging. For example, the Facebook site DIEPC Journey, the breast reconstruction blog, has enabled many stakeholders, like PRMA, to educate the public and communicate directly with breast cancer and previvor patients.[19] Social media posts must be frequent and consistent. Tracking referrals and conversion-to-surgery rates has been useful for our practice.[20] This takes time and energy; PRMA employs a full-time social media liaison. Social media can be problematic; public response and messaging by nonplastic surgeons can be unpredictable and unfavorable.[18,20] At PRMA, some social media platforms, for example, YouTube, remain underutilized.[21] This is an avenue of growth for PRMA. Demonstrating practice transparency builds trust.

PILLAR 2: OBTAIN FUNDING

To start your practice, you will need to obtain funding. We recommend developing a relationship with a local or regional bank. A smaller bank may offer more personalized service, and they may even have a dedicated individual who oversees physician practice development and support. You will need a loan or line of credit. You will likely be required by the lender to create an overall business plan and to create a pro forma to predict expense and revenue trends.[22,23] One might consider obtaining funding through a venture capital entity.[22] The advantages of aligning your practice with a larger venture capital-backed entity might include initial and long-term financial support, tapping into cost-saving supply chain and service contracts, and support for expansion of service lines and hiring of new physicians and additional staff. However, entering a relationship with a venture capital-backed entity will likely introduce oversight into your practice with productivity metrics, guidelines on what type of staff should be hired, and the timing of staff hiring. Consider the tradeoffs. Another avenue for funding is to establish relationship with a hospital and to demonstrate your value to the hospital as an effective revenue generator; a private solo practitioner, or private group, might be able to receive a stipend (or even full funding) from the hospital.[24] Make use of services offered by the American Society of Plastic Surgeons for starting a private practice.[25]

Takeaways

Question: Why and how would one start a private practice based on microsurgical breast reconstruction?

Findings: The article describes how to start and develop a microsurgical breast reconstruction practice in the private setting.

Meaning: One can successfully start and sustain a microsurgical breast reconstruction practice by following five key steps: (1) establishing a vision; (2) obtaining funding; (3) assembling staff; (4) negotiating; (5) focusing on efficiency and sustainability.

PILLAR 3: ASSEMBLE STAFF

The core staff required to start a microsurgical breast reconstruction practice includes a practice administrator, nurse, billing specialist, nonsurgical clinic (front-end) scheduler, and surgical scheduler.

Table 1. Summary of Key Points of the Five Pillars

Pillar 1	Establish a vision and formulate a culture	• Define service lines—core service of microsurgical breast reconstruction. • Educate community practitioners about autologous tissue breast reconstruction. • Utilize social media platforms to educate the public about autologous tissue breast reconstruction and your practice.
Pillar 2	Obtain funding	• Create a business plan. • Loan or line of credit—local/regional bank. • Venture capital funding. • Hospital-based funding.
Pillar 3	Assemble staff	• Practice administrator. • Office clinical staff-nurses or nurse practitioners. • Surgical clinical staff-physician assistants. • Nonclinical staff—billers, schedulers, patient liaison.
Pillar 4	Negotiate	• Develop relationships with the dominant carriers in your geographic area. • Utilize practice outcomes data and case and general overhead costs to negotiate favorable reimbursement rates. • Demonstrate leadership to the carriers your leadership in microsurgical breast reconstruction—volume and outcomes.
Pillar 5	Strive for efficiency and sustainability	• Co-surgeon model. • Physician assistants. • Focus on patient experience. • Practice structure—CEO, COO, practice administrator, office manager. • Planning meetings. • Compensation model. • Efficient billing and collections.

Assemble employees who contribute to and enhance the culture of your practice. A breast reconstruction requires a mature, nurturing staff. Err on the side of hiring more qualified people rather than less qualified. Do your homework for prospective employees and hire the best people you can afford for each position.[26] Aim for efficiency. For example, a nurse or nurse practitioner, as opposed to say a medical assistant, may be able to see patients independently in the clinic setting while you are performing surgery-generating revenue. The surgeons of PRMA generally operate 4–5 days/week; the clinic time is kept to a minimum. The use of physician extenders has been shown to enhance productivity, decrease complications, reduce surgeon fatigue, and maximize throughput.[27,28] A physician assistant who can assist in the operating room, make rounds, and write orders independently frees the surgeon to perform a greater number of cases with the potential positive effect on revenue.[29]

An essential hire for a microsurgical breast reconstruction practice is the practice administrator. Ideally, this should be someone who has broad experience with hiring personnel, billing, collections, and HR. Additional critical skill sets include basic accounting and knowledge of the private insurance industry. Critical to the success of PRMA was early on hiring an outstanding practice administrator who was trained as a forensic accountant and who had extensive knowledge of the insurance landscape locally and nationally. This individual has proved to be a skillful negotiator with the insurance carriers to obtain negotiated contracts for our microsurgical breast reconstruction procedures.

Initial core staff also includes a billing specialist, front office scheduler, and surgical scheduler. The billing specialist must understand the complexities of billing for microsurgical breast reconstruction procedures. At the time of start up to keep overhead low, it may be necessary to have one person who performs both clinic and surgical scheduling. Obtaining preauthorization from the insurance carriers and coordinating breast reconstruction with other surgeons is a time-consuming process; as the practice grows, you will require a dedicated surgical scheduler. At PRMA, we have a staff of schedulers, one of whom is dedicated solely to scheduling DIEP flaps. The billing specialist must have experience in coding or be able to learn the CPT and ICD 10 codes specific to microsurgical breast reconstruction. It takes time, several months to over one year, to find and credential new staff. If we have made a mistake in our hiring practices it has been in waiting too long to hire additional personnel to meet the growth needs of the practice.

PILLAR 4: NEGOTIATE

Seek to optimize contractual reimbursement agreements with insurance companies. Understand who the dominant carriers are in your geographic area. Identify the major employers in your area and who their insurance carriers are. This might include school districts, moderate-to-large private companies, and service sector companies. Focus on the major carriers in your geographic area. Over time, one can develop carve-outs with carriers who have a minority position in the community. Success in obtaining a carve-out with a dominant major carrier in your community can lead to success in obtaining carve-outs with smaller carriers. Kind et al in a 2021 article outlines multiple strategies one could use to obtain carve outs; any or all these approaches could be applied to microsurgical breast reconstruction reimbursement.[29]

The ability to obtain negotiated contracts will be impacted by the elimination of the S codes that describe microsurgical breast reconstruction, specifically S2066–S2068, set to expire on December 31, 2024. After this date the DIEP flap, and other free flaps used in breast reconstruction, will be described by CPT 19364.[30] The S codes do not have set numerical relative value units (RVUs); historically we at PRMA have found this helpful in the negotiation process as there was no set limit to the reimbursement amount compared to using a level one CPT code such as 19364, which carries a specific number of RVUs to which a Medicare multiplier is applied, creating a ceiling for reimbursement.

PRMA utilizes its knowledge of practice general overhead costs, human capital costs, and administrative costs—the total cost per case—to help negotiate favorable rates of reimbursement for DIEP flaps. Human capital costs include, for example, time spent authorizing and scheduling procedures, physician time in the OR, and time spent with billing and collections. In addition, the practice administrator has in mind a dollar per hour figure that is set as a floor to meet desired physician salary requirements.[2,3,29] Desired physician salaries are determined in part by evaluating local and national plastic surgery salaries and benefits data.[2,3]

Historically using the S codes, we have been able to negotiate fair and favorable rates of reimbursement for free flap breast reconstruction procedures. Moving forward, with the loss of the S codes, the challenge will be to negotiate carve-outs using CPT 19364. Here, the strategy obtains Medicare multiples that exceed practice overhead and meet personal revenue requirements.

PRMA has been successful in maintaining negotiated reimbursements through a process of planned, highly structured meetings with the major insurance carriers. The single biggest contributor to our success in negotiating contracts is the professional relationships that we have developed and maintained with local, regional, and national insurance carrier representatives. Our practice administrator routinely presents outcome data to insurance carrier representatives to demonstrate a high level of competence in microsurgical breast reconstruction utilizing the co-surgeon model,[31–34] emphasizing a high flap success rate, low complication rate, short hospital stays, and high degree of patient satisfaction. Improvements in outcomes, for example, a reduction in hospital length of stay, or a DIEP flap success rate approaching 100%, are presented to carrier representatives. Contracts are typically renegotiated every 2 years. However, in some cases, depending on the willingness of the carrier to negotiate, contracts are renegotiated every year using annually updated practice volume and outcome data.

Demonstrate to the carriers that you are a leader in microsurgical breast reconstruction. Keep track of flap

case type and volume. Know the reconstructive surgical demographics of your community and be able to demonstrate that you are a volume and quality leader in the field of microsurgical breast reconstruction.[33] It took PRMA approximately 3 years to accumulate enough high-quality data that were of use in negotiating carve-outs for microsurgical breast reconstruction with insurance carriers. Many plastic surgeons *say* they perform microsurgical breast reconstruction; challenge the carriers to investigate for themselves who in the community is performing microsurgical breast reconstruction.

Together the PRMA, practice administrator, and billing specialists are aggressive in keeping accounts receivable current. The administrator routinely monitors reimbursements to make the carriers pay us according to our negotiated contracts. Overages in payments are promptly returned to the carrier. This builds goodwill. On the other hand, underpayment prompts a discussion with the carrier to reimburse us according to the contract. Contract negotiations are revisited frequently to maintain reimbursement consistency.

The concept of negotiation can be extended to other areas of the practice. We routinely negotiate prices for goods and services. Supply chain analysis, common to other industries, has not traditionally been common in medical practices but is becoming recognized as an important tool in controlling costs.[35]

PILLAR 5: STRIVE FOR EFFICIENCY AND SUSTAINABILITY

Think team. We started in PRMA in 1994 with two microsurgical-trained physicians, working together as cosurgeons, which to our knowledge had never been done before in a private practice community hospital setting. The two-physician approach allowed for a division of labor and brought efficiency to what at the time were long, unpredictable cases usually performed in an academic setting. The benefits of a two-physician team approach are now well documented.[31–34,36] PRMA has tremendous corporate knowledge with eight physicians and seven long-tenured physician assistants. We have an established intraoperative sequence of steps that brings consistency and reliability to the DIEP flap procedure.[37] The practice has an aggregate experience of over 12,000 individual DIEP flaps. High body mass index, previous abdominal surgery, and comorbidities create intraoperative and postoperative challenges. Case selection is critical.[38] The team approach and high volume make challenging cases—unfavorable anatomy, chest wall radiation, scarring from previous abdominal surgery, the need for additional venous outflow—doable on a routine basis, with a high degree of success.[33] With two or more physicians, there is an uninterrupted revenue stream and greater overall profitability.

Although it is possible to perform microsurgical breast reconstruction as a solo surgeon practitioner, there are significant downsides such as fatigue, managing difficult or unexpected intraoperative problems, managing complications such as take backs, and not being able to have reliable protected time off. In our view, the solo practitioner would require a physician extender to assist in the operating room and help with other clinical tasks.[27–29]

The main challenge of starting a practice with two physicians is generating enough revenue, especially early on, to support two physicians and the requisite staff. The challenge is to maintain a shared vision in terms of the core service of the practice, expansion of service lines, and addition of physicians and staff. When hiring new physicians, make sure they are qualified to perform microsurgical breast reconstruction and that they want this to be the core of their practice.

In terms of efficiency, focus on patient experience. Understand how patients enter and then flow through your practice. PRMA is based in San Antonio, TX. This is a large urban area, and the practice has a variety of referral sources locally and regionally. In addition, because of our persistent messaging and consistency in maintaining our core service of tissue transplant breast reconstruction, we have become a destination practice for breast reconstruction. The practice now has a dedicated patient liaison to help coordinate its out of state patients. Telemedicine has become an important part of our intake of patients from Texas and out of state patients.[39] although essential and effective, at PRMA we have found that telemedicine visits can limit the ability to perform accurate physical examination and are more time-consuming than in-person visits. Not all patients are comfortable utilizing the necessary technology or with the level of understanding provided by the visit.[40,41]

Strict adherence to an ERAS protocol ensures that hospital stays are minimized and that patients recover quickly and comfortably.[42]

PRMA began as an independent private practice. In January of 2023, the practice became an affiliate of a larger practice entity, ARSA, which includes microsurgical reconstructive practices throughout the United States. We made this decision to capitalize on economy of scale, strengthen our negotiating power with insurance carriers, and further expand our footprint. Long-term sustainability has been and will continue to be achieved through yearly long range planning meetings and quarterly quality assurance meetings and partners meetings. We have an intrapractice leadership team, which includes a CEO, COO, practice administrator, and an office manager. We have retained the services of a corporate counselor planner. Meetings with the corporate planner have enabled us to voice individual and group concerns, resolve disputes, and maintain the long-term practice vision. These can be challenging meetings; however, once concluded, the physician leadership and partners can present a unified front to physician associates and staff. To ensure sustainability, PRMA periodically undertakes a market analysis of our nursing, administrative, and nonadministrative staff to make sure that our salary and benefits packages are competitive for our geographic area.

At PRMA, we have a combined base salary and productivity-based model of compensation.[43] Productivity is assessed by tabulating RVUs. There is a wide range of productivity within the group, ranging from 14,002 to 23,000 RVUs per year. Sustainability depends upon

assessment of, and agreement on, individual and aggregate productivity. Work templates are reviewed and reset annually to define paid leave, RVU productivity expectations, clinic time, and operative time.

Central to sustainability is efficient insurance authorization, billing, and collections. The practice administrator and billing personnel must work as a team to keep accounts receivable current. At PRMA, we consistently maintain accounts receivable between 88% and 92% of outstanding claims at or less than 30 days. This is accomplished by prompt and accurate billing of claims soon after the service is performed. We have coding and billing protocols built into our fee schedules, which helps ensure biller proficiency, and which ultimately eliminates claims being unduly denied. Claim status is checked on day 14, and then every 5 days thereafter. The billers are knowledgeable about ICD 10 breast diagnosis codes, CMS coding rules, and NCCI edits[44]; they keep up with PSN Coding Corner reports. The billing staff make frequent use of the insurance company portals and Availity to assess the status of a claim.[45] The practice administrator and billing staff have developed good relationships with carrier provider advocates, who can expedite claim processing and reimbursement.

CONCLUSIONS

With careful planning and attention to the five pillars presented, starting and maintaining a practice in microsurgical breast reconstruction is indeed possible. The concepts presented in the five pillars are as applicable today as they were 29 years ago. Consider working with one or more microsurgical-trained physicians and make use of physician extenders to gain efficiency. Hire and retain well-qualified, skillful nursing and administrative staff. Social media and telemedicine, which did not exist when PRMA was founded, must be considered. Integrating these tools can enhance practice reach and efficiency. Utilize practice data to effectively negotiate favorable rates of reimbursement. Performing breast reconstruction in a private practice setting can be financially rewarding, and affords the surgeon independence, flexibility, and a measure of control.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

REFERENCES

1. Baimas-George M, Fleischer B, Korndorffer JR Jr, et al. The economics of private practice versus academia in surgery. *J Surg Educ.* 2018;75:1276–1280.
2. McKenna J. Medscape plastic surgeon compensation report 2022: incomes gain, pay gaps remain. 2022. Available at https://www.medscape.com. Accessed May 16, 2023.
3. Data Report: 2022 MGMA DataDive provider compensation—realizing recovery. Available at https://www.mgma.com. Accessed May 16, 2023.
4. Carbullido MK, Hornacek M, Reid CM, et al. Career development in plastic surgery. *Plast Reconstr Surg.* 2021;147:1441–1449.
5. Gallus K. Starting a private plastic surgery practice from scratch. Available at https://opmed.doximity.com/articles/starting-a-private-plastic-surgery-practice-from-scratch?_csrf_attempted=yes. Accessed May 18, 2023.
6. American Cancer Society. Cancer facts & figures 2023. Available at https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/2023-cancer-facts-figures.html. Accessed May 16, 2023.
7. Shaheen MS, Momeni A. Nationwide trends in contralateral prophylactic mastectomies: an analysis of 55,060 unilateral breast cancer patients. *Plast Reconstr Surg Glob Open.* 2022;10:e4344.
8. Ludwig KK, Neuner J, Butler A, et al. Risk reduction and survival benefits of prophylactic surgery in BRCA mutation carriers, a systematic review. *Am J Surg.* 2016;212:660–669.
9. Ochoa O, Garza R III, Pisano S, et al, Prospective longitudinal patient-reported satisfaction and health-related quality of life following DIEP flap breast reconstruction: effects of reconstruction timing. *Plast Reconstr Surg.* 2022;149:848e–857e.
10. Ochoa O, Garza R III, Pisano S, et al. Prospective longitudinal patient-reported satisfaction and health-related quality of life following DIEP flap breast reconstruction: relationship with body mass index. *Plast Reconstr Surg.* 2019;143:1589–1600.
11. Erdmann-Sager J, Wilkins EG, Pusic AL, et al. Complications and patient-reported outcomes after abdominally based breast reconstruction: results of the mastectomy reconstruction outcomes consortium study. *Plast Reconstr Surg.* 2018;141:271–281.
12. Asaad M, Slovacek C, Mitchell D, et al. Surgical and patient-reported outcomes of autologous versus implant-based reconstruction following infected breast device explantation. *Plast Reconstr Surg.* 2022;149:180e–1089e.
13. DellaCroce FJ, DellaCroce HC, Blum CA, et al. Myth-busting the DIEP flap and an introduction to the abdominal perforator exchange (APEX) breast reconstruction technique: a single-surgeon retrospective review. *Plast Reconstr Surg.* 2019;143:992–1008.
14. Macadam SA, Zhong T, Weichman K, et al. Quality of life and patient-reported outcomes in breast cancer survivors a multicenter comparison of four abdominal based autologous reconstruction methods. *Plast Reconstr Surg.* 2016;137:758–771.
15. Dayan JH, Allen RJ Jr. Lower extremity free flaps for breast reconstruction. *Plast Reconstr Surg.* 2017;140:77S–86S.
16. Mrad MA, Al Qurashi AA, Mortada H, et al. Do our colleagues accurately know what we do? *Plast Reconstr Surg Global Open.* 2022;10:e4104.
17. Janik PE, Charytonowicz M, Szczyt M, et al. Internet and social media as a source of information about plastic surgery: comparison between public and private sector, a 2-center study. *Plast Reconstr Surg Global Open.* 2019;7:e2127.
18. Ben NY, Duek OS, Rafaeli S, et al. Plastic surgery faces the web: analysis of the popular social media for plastic surgeons. *Plast Reconstr Surg Global Open.* 2018;6:e1958.
19. Coutee T. DIEPC journey—breast reconstruction after mastectomy. Available at Facebook. Accessed August 14, 2023.
20. Chang J, Woo SL, Cederna S. Worth the "Likes?" The use of Facebook among plastic surgeons and its perceived impact. *Plast Reconstr Surg.* 2015;135:909e–918e.
21. Almarghoub MA, Alghareeb MA, Alhammad AK, et al. Plastic surgery on YouTube. *Plast Surg Global Open.* 2020;8:p e2586.
22. Small Business Administration. Plan your business. Available at https://www.sba.gov/business-guide/plan-your-business/write-your-business-plan. Accessed May 20, 2023.

23. Ultimate Startup Pro Forma Spreadsheet Template. Available at https://www.youexec.com/plus. Accessed May 20, 2023.
24. Ellsworth WA IV, Gratzon AC, Friedman JA. The business of employed plastic surgery: creating your seat at the table. *Plast Reconstr Surg.* 2022;149:989–998.
25. American Society of Plastic Surgeons Practice Resources PS2 Consulting Services. Available at https://www.plasticsurgery.org/ps2-practice-management. Accessed May 20, 2023.
26. Gallus K. Starting a private plastic surgery practice from scratch. Doximity OpMed. 2018. Available at https://opmed.doximity.com/articles/starting-a-private-plastic-surgery-practice-from-scratch?_csrf_attempted=yes. Accessed May 20, 2023.
27. Althausen PL, ShannonS, Owens B, et al. Impact of hospital-employed physician assistants on a level ii community-based orthopaedic trauma system. *J Orthop Trauma.* 2013;27:e87–e91.
28. Bohm ER, Dunbar M, Pitman D, et al. Experience with physician assistants in a Canadian arthroplasty program. *Can J Surg.* 2010;53:103–108.
29. Kind GM, Davis MJ, Abu-Ghname A, et al. Carving out financial success: the power of insurance carve-outs in a private plastic surgery practice. *Plast Reconstr Surg.* 2021;148:239–246.
30. Kozlow J, Schnur D, Shale C, et al. Breast reconstruction coding evolution creates challenges. *CPT Corner.* 2023:10,11,28.
31. Mericli AF, Chu CK, Sisk G, et al. Microvascular breast reconstruction in the era of value-based care: use of a cosurgeon is associated with reduced costs, improved outcomes, and added value. *Plast Reconstr Surg.* 2022;149:338–348.
32. Razdan SN, Panchal HJ, Hespe GE, et al. The impact of the cosurgeon model on bilateral autologous breast reconstruction. *J Reconstr Microsurg.* 2017;33:624–629.
33. Ochoa O, Pisano S, Ledoux P, et al. Case volume-dependent changes in operative morbidity following free flap breast reconstruction: a 15-year single-center analysis. *Plast Reconstr Surg.* 2021;148:365e–374e.
34. Weichman KE, Lam G, Wilson SC, et al. The impact of two operating surgeons on microsurgical breast reconstruction. *Plast Reconstr Surg.* 2017;139:p277–p284.
35. Reece EM, Davis MJ, abu-Ghname A, et al. Working smarter, not harder: using data-driven strategies to generate front-end cost savings through price negotiation and supply chain optimization. *Plast Reconstr Surg.* 2022;149:1488–1497.
36. Gosseringer N, Mani M, Cali-Cassi L, et al. Benefits of two or more senior microsurgeons operating simultaneously in microsurgical breast reconstruction: experience in a Swedish medical Center. *Microsurgery.* 2017;37:p416–p420.
37. Haddock NT, Teotia SS. Deconstructing the reconstruction: evaluation of process and efficiency in DIEP inferior epigastric perforator flaps. *Plast Reconstr Surg.* 2020;145:717e–724e.
38. Ochoa O, Chrysopoulo M, Nastala C, et al. Abdominal wall stability and flap complications after deep inferior epigastric perforator flap breast reconstruction: does body mass index make a difference? An analysis of 418 patients and 639 flaps. *Plast Reconstr Surg.* 2012;130:21e–33e.
39. Xue EY, Chu CK, Winocour S, et al. Establishing a telemedicine program for breast reconstruction. *Plast Reconstr Surg Global Open.* 2020;8:e2594.
40. Calderon T, Skibba KEH, Langstein H. Plastic surgeons nationwide share experience regarding telemedicine in initial patient screening and routine postoperative visits. *Plast Reconstr Surg Global Open.* 2021;9:e3690.
41. Horen S, Alba B, Siotos C, et al. Telemedicine in plastic surgery. *Plast Reconstr Surg Global Open.* 2021;9:114–115.
42. Ochoa O, Rajan M, Garza R, III, et al. Enhanced enhanced recovery pathway reduces hospital stay and opioid use in microsurgical breast reconstruction: a single-center, private practice experience. *Plast Reconstr Surg.* 2022;150:13e–21e.
43. Lopez J, Offodile AC, Shenaq D, et al. Plastic surgeon financial compensation-incentivization models in surgical car delivery: the past, present, and future. *Plast Reconstr Surg.* 2021;148:1415–1422.
44. Medicare National Correct Coding Initiative (NCCI) Edits. 2023. Available at https://www.cms.gov/ncci-medicare. Accessed May 18, 2023.
45. Availity. Available at https://www.availity.com. Accessed May 21, 2023.