By Dawn Cook, RN, CLCP, CNLCP

# How to Craft a Surgical Letter

## Understanding the costs associated with surgery upfront is important for both patients and payers.

A surgical letter includes the expected costs a surgeon anticipates for a specific surgery. The purpose of the letter is to provide a budget for preoperative care, costs on the day of surgery, and postoperative care. The letter may be created for a cash-paying patient, as an insurance requirement, or for insurance settlement purposes.

When tasked with crafting a surgical letter, it's important to ask yourself:

- What do I need to include in the letter?
- How do I learn the medical-specific codes?
- Where do I find the costs for each item?

This article will instruct how to address these questions in all stages of care when compiling a surgical letter.

### Gather Essential Information

As an employee of a surgeon's office, you have an advantage when trying to locate direct charges for surgery. Your surgeon has a relationship with other physicians, therapists, and facilities who will likely give you information that would be difficult or impossible to learn otherwise. When contacting other facilities for pricing, emphasize that you are calling from your physician's office and be prepared to name the patient, their date of birth, the proposed surgery, and the reason for the request.

Once you have what you need, you can create a letter that includes each item and a cost estimate (including where you found the cost). Once the letter is approved by your office, your physician can then determine the best way for the patient to receive the letter. They may wish to review it with the patient at their next office visit or send it to them immediately.

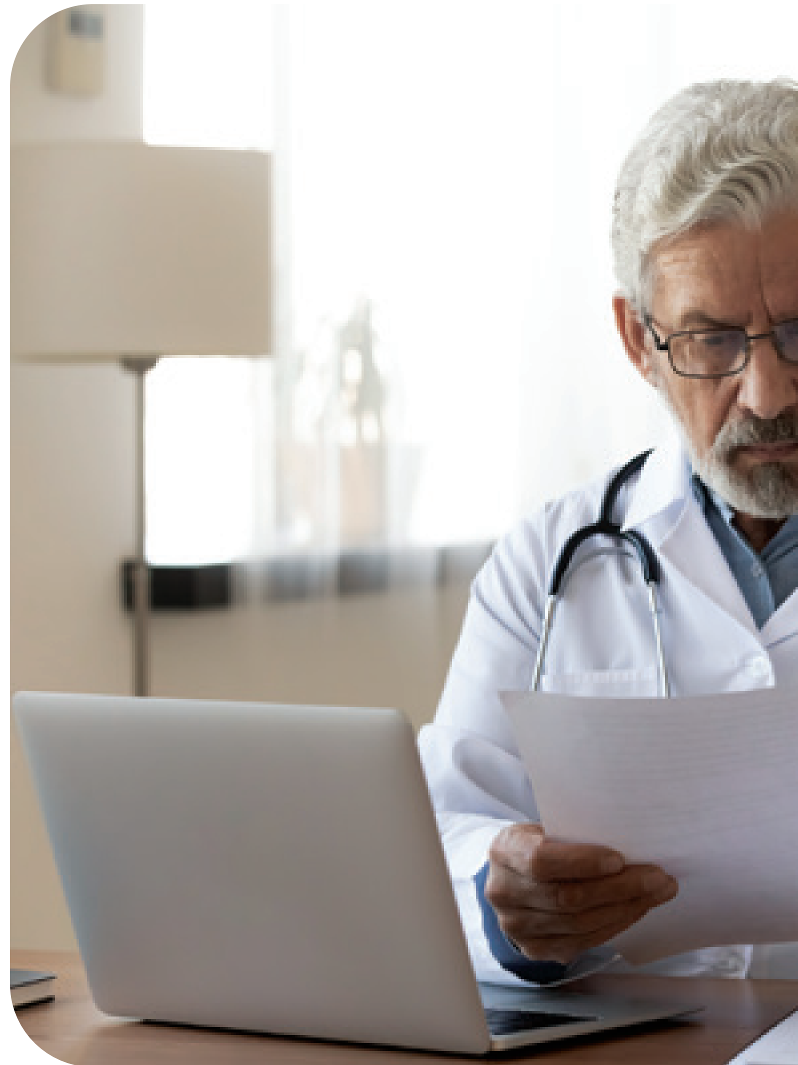
### Find the Costs and Codes

When crafting a surgical letter, you will need to have a list of all pre- and postoperative care that your surgeon is recommending, details concerning the type of facility, and the CPT® codes associated with the specific surgery. Prepare a list of questions and then talk with the medical assistant or surgeon about each state of care.

**Preoperative Care:**

1. Preoperative assessment by a surgeon, usually a consultation, is usually coded with:

   **99244** Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded



If you work in a medical office, you can determine the cost that your office charges by consulting your chargemaster or billing department.

2. Preoperative clearance by a primary care provider (PCP) or a pediatrician in the case of a child is needed. This is usually a consultation, even if the patient usually sees this provider regularly, to accommodate the extended nature of the visit. The usual CPT® code is 99244. If your office does not provide this service, contact the office of your patient's PCP and ask for help determining the usual charge for this.

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3. For labs and radiology or diagnostic imaging contact your local laboratories and ask for their direct pay charge sheet, explaining that you are preparing a surgical projection and need their charges. You will need to give the CPT® codes for each item that your patient will need, and you may need to give this verbally over the phone or in writing by email or fax. For inpatient surgery, labs and radiology may need to be done at the facility where the surgery will be done. You can ask about these costs when you call for facility costs.
4. Cardiac and respiratory assessments are consultations with the respective physician specialists. You can call the office that you will be referring the patient to to determine the consultation fee, any testing fees, and any follow-up charges.
5. A physical therapy (PT) preoperative evaluation is reported with:

   **97162** Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family

   Call the PT office that you usually refer your patients to and ask for help with direct pay charges. Ask whether more than one visit will be needed if additional equipment evaluations are needed.
6. Most durable medical equipment and supplies can be purchased from department stores and larger pharmacies. Do an online search for well-known retail providers to determine the cost for each item. If there are unusual items, such as scooters, ice machines, or continuous movement machines, you may need to call your local medical supplier.

**Day of Surgery:**

1. Facility costs may be available to your office if your surgeon regularly does surgery there. Determine if you should call the billing department, the operating room, or another department. Be prepared to give information on the specific surgery and the patient's comorbidities. ICD-10 codes may also be needed.
2. Ask the surgeon what specific surgery they are planning, including any additional procedures that might be needed. Ask if an assistant to the surgeon is needed for this surgery. Then use your own chargemaster for the associated CPT® codes. If your surgeon uses an outside medical group for providing an assistant, call them for an estimate.
3. If the patient will receive a pass-through implant, such as a pulse generator, there will be additional charges from the facility for this equipment if done at an outpatient facility. This is usually included in the hospital charge for inpatient care.

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4. If it's anticipated that there will be any equipment, such as a leg brace or ice pad placed on the patient immediately following surgery, be sure to get the cost for this, as it usually constitutes an additional charge.
5. Hospitalists may be needed if the patient is staying overnight to manage other medical conditions they may have. Call your local hospitalist group to determine their costs — they usually charge more for the admission date and the discharge date than they do for daily visits. The usual CPT® codes for this care are:

**99221** Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

**99231** Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded

**99238** Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter

6. Anesthesia costs are best determined by calling the anesthesia group that works with your surgeon. You will need to provide the CPT® codes for surgery and information on any comorbidities (usually by providing the ICD-10-CM codes).
7. Neuromonitoring for spine, brain, or other surgery is sometimes needed. There may be a group that provides these services at your facility. Call them and ask what the charge will be for the service, providing all CPT® codes for the surgery and the patient's comorbidities or ICD-10-CM codes.

**Postoperative Care:**

1. Medication prices can be obtained by calling the patient's usual pharmacy or using an online service such as www.GoodRx.com.
2. Follow-up physician office visits are included in the global period (90 days for most surgeries). Determine how often your surgeon will want to see the patient back in the office and whether X-rays will be done there. Although the office visit in the first 90 days has no charge, site-specific X-rays may be charged for. Check your office's chargemaster to determine the usual charge for X-rays and the cost for any office visits that may occur past the 90-day global period.
3. Physical or occupational therapy evaluation and the number of sessions can usually be determined by the surgeon ahead of time. Sessions are usually 1 hour. Call the PT office that you usually refer your patients to and ask for help with direct pay charges.
4. Possible home nursing and therapy is based on the patient's condition and whether they have support at home. The patient may need additional help in the first two weeks, including having their dressings checked by a nurse at home, as well as the initial PT evaluation and therapy done at home. Call your usual PT office for costs. Nursing home visit costs can be obtained from home health or nursing agencies.

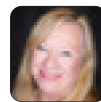
*"To get a cost estimate for housecleaning and meal preparation, do an internet search or ask the patient if they sometimes use a cleaning agency."*

5. It is possible that a rehab hospital will be needed for those with comorbidities or lack of assistance at home. Ask your surgeon approximately how long the patient should be in rehab and whether they will need help at home. Call the usual rehabilitation facility that your surgeon uses to determine their costs. They may have a daily rate plus additional therapy charges.
6. Depending on the surgery, the patient may not be able to bathe or do housework without assistance for a period of time following their return home. Consider that an agency may need to send a home health aide to assist with personal care. This can be determined by a phone call to a few agencies in your area. To get a cost estimate for housecleaning and meal preparation, do an internet search or ask the patient if they sometimes use a cleaning agency.

These lists may not be all-inclusive depending on the surgery in question. Consider any additional medical needs not outlined here. For those anticipating that insurance may cover some of these costs, talk with your billing specialist. Many of the above items are not covered or only partially covered.

## Reap the Rewards

A surgical letter must include all the components needed for surgery — nothing is to be left out. Learning how to craft a surgical letter is a lengthy process, and creating a complete surgical estimate is time-consuming; however, the benefits to patients and payers is well worth the hard work. **HBM**

**Dawn Cook, RN, CLCP, CNLCP,** is a registered nurse and life care planner with 45 years of experience. She has completed over 700 life care plans and 450 medical bill reviews. Cook will present "Crafting Surgical Letters and Cost Estimates" at HEALTHCON 2023.

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