A STUDY TO DETERMINE

THE FEASIBILITY OF ESTABLISHING AN AMBULATORY SURGERY PROGRAM AT KELLER ARMY COMMUNITY HOSPITAL WEST POINT, NEW YORK

A Graduate Research Project

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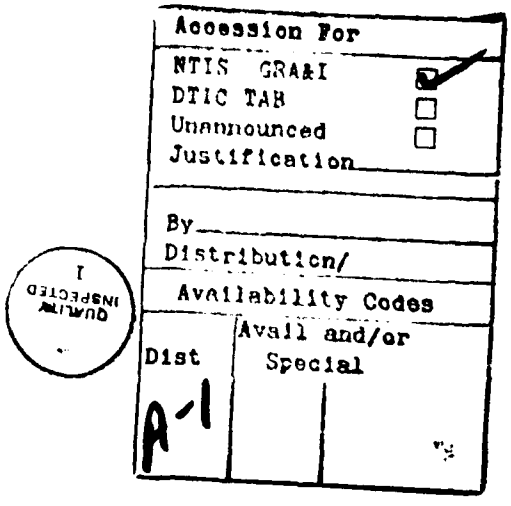


I. INTRODUCTION

Ambulatory surgery is defined as, "elective minor or intermediate surgery carried out under local or general anesthesia, on patients who are admitted and discharged the same day" (Burn, 1979). It is presently one of the most rapidly growing areas of the American health care delivery system. In a survey conducted by the American Hospital Association in 1985, 34 percent of the total number of surgical procedures performed were done on an outpatient basis (Nathanson, 1986). It is estimated that by 1990, 60 percent of the surgeries performed will be done on an outpatient basis (Curtin, 1984). Ambulatory surgery appears to be well on its way to being firmly established as an alternate method of health care delivery.

Although ambulatory surgery has become fairly common in the civilian community, it is relatively new to the Army Medical Department. As such, only a handful of military hospitals, primarily medical centers, offer this type of surgery. In an effort to catch up with the civilian community, the Department of Defense and subsequently the U.S. Army Health Services Command have published new guidelines to encourage the development and implementation of outpatient surgery programs in military treatment facilities. This move toward ambulatory surgery is intended not only to increase workload, but reduce costs by allowing military hospitals to treat patients who, in the past, may have had to seek care in civilian hospitals (Young, 1986).

Keller Army Community Hospital (KACH) is a 65-bed medical treatment facility located at West Point, New York. Its primary mission is to provide both inpatient and outpatient care for the United States Corps of Cadets and military personnel and families assigned to West Point.

The hospital has two Operating Room suites. Although the hospital does not experience a large backlog of surgeries, establishing an ambulatory

surgery program would allow for the surgical specialities to relieve their case backlogs without increasing the number of hospital beds occupied. However, before such a program could be implemented a comprehensive study was required in order to determine if an ambulatory surgery program was justified.

It was this current interest in performing inpatient procedures on an outpatient basis that prompted this writer to design a study that would not only determine the feasibility of performing surgery on an ambulatory basis, but develop a set of procedures for implementing and operating an ambulatory surgery clinic. The methodology by which this project will be conducted along with the results of the research will be presented in the remainder of this paper.

Statement of the Research Problem

To conduct a comprehensive study to determine the feasibility of establishing an ambulatory surgery program at Keller Army Community Hospital and if feasible, develop implementation plans.

Objectives

1. To conduct a literature review on the topic of ambulatory surgery.
2. To conduct interviews with those personnel who will be involved with ambulatory surgery in order to identify perceptions, problems, and recommendations prior to development and implementation of an ambulatory surgery program.
3. To determine if the alternative method of providing surgery will be accepted by both the physician and beneficiary population at West Point.
4. To determine if implementation of an ambulatory surgery program would result in a reduction in the current surgical output.

5. To determine if implementation of an ambulatory surgery program will increase the total number of surgeries done at Keller thus increasing the surgical workload and MCCUs produced.

6. To contact other health care organizations that have established ambulatory surgery programs and obtain copies of their operating procedures.

7. To determine the best location within the hospital in which to locate the Ambulatory Surgery Unit.

8. To develop a patient flow sequence that facilitates entry, treatment, and discharge of patients who use the Ambulatory Surgery Unit.

9. To determine the projected impact of ambulatory surgery on Medical Care Composite Units (MCCUs) given the current workload.

10. To develop policies and procedures for the following areas:

    a. Admissions

    b. Patient selection criteria

    c. Handling of narcotics

    d. Discharge criteria from the Recovery Room

    e. Discharge criteria from the Ambulatory Surgery Unit

    f. Quality assurance

    g. Anesthesia service

    h. Safety

    i. Scheduling

11. To develop a plan for implementing the ambulatory surgery program.

Criteria

1. That the policies and procedures developed be consistent with JCAH, The American College of Surgeons and HSC Pamphlet 40-7-3.

2. That the total number of surgeries performed be greater than the total

number of surgeries performed prior to establishing the ambulatory surgery program.

Limitations

1. Only existing resources will be used to staff and operate the ambulatory surgery program.
2. There will be no new construction available for implementation of this program.

Assumptions

That an increase in the total number of surgeries performed would aid in decreasing the surgical backlog and free up Operating Rooms for more acute care.

Research Methodology

This section contains an overview of the seven steps used to access the objectives.

Step 1 - Literature Review

Journal articles and publications will be reviewed to determine procedures, trends and policies that govern the establishment and operation of ambulatory surgery programs. This information will aid in identifying potential problem areas and provide a base from which to develop guidelines for the operation of an Ambulatory Surgery Unit.

Step 2 - Interviews

Personal interviews will be conducted with department and service chiefs in order to elicit their personal and professional concepts, beliefs, ideas and criticisms concerning ambulatory surgery. In addition, a questionnaire will be developed and distributed to both the medical staff and patient population in order to obtain a wider scope of opinions as to whether or not ambulatory surgery should be done at KACH. This information will assist in

identifying potential problem areas that should be addressed and resolved prior to implementing an ambulatory surgery program.

Step 3 - Outside Agencies

Contact with other health care organizations within the Army and West Point area, that have established ambulatory surgery programs, will be made in an attempt to obtain copies of their operating procedures. The information will provide not only a base from which to develop guidelines for the operation of an ambulatory surgery program, but aid in developing a recommended list of surgical procedures that could be performed in an Ambulatory Surgery Unit.

Step 4 - Workload Analysis

From the information provided by the Department of Army letter dated 31 December 1986, the Automated Quality Care Evaluation System (AQCESS) and the Patient Administration Systems and Biostatistics Activity (PASBA), an analysis will be performed of those surgical procedures conducted in both the Operating Rooms and as clinical procedures. The first part involves a review of the surgery log books from the Operating Rooms. Those procedures which qualify as ambulatory surgery procedures will be extracted and then impact on total MCCU production assessed. Next, the log books from the outpatient clinics will be reviewed to determine which cases could have been performed in an Ambulatory Surgery Unit. A comparison of the total number of MCCUs generated under the current system as compared to the number of MCCUs produced had the procedures been done in an Ambulatory Surgery Unit will be made. This information will be utilized to assess the projected impact of ambulatory surgery on MCCU production at KACH.

Step 5 - Site Selection

A major problem initially identified concerned the physical requirements

of the Ambulatory Surgery Unit. In order to determine possible areas for the unit, blueprints of KACH along with current utilization will be reviewed. A decision paper will then be written and submitted to the Hospital Commander identifying areas in which the unit could be located. Once the site has been identified, a patient flow chart will be developed.

Step 6 - Policies and Procedures

Using information obtained from the preceding steps, policies and procedures will be formulated for the operation of an ambulatory surgery program.

Step 7 - Implementation

Using information obtained from the preceding steps, a plan for implementing the ambulatory surgery program will be developed.

II. LITERATURE REVIEW

Development and Growth

Hospitals, at least in the mind of some consumers, have come full circle in less than a century. At the beginning of this century, hospitals were often as much almshouses as health care facilities. Most middle class and wealthy patients who had surgery chose to recover at home. It was the indigents and soldiers who suffered the fate of hospital care. As technology and modern hospitals developed, hospitals soon became the preferred place to receive medical care. However, we seem to be entering another new age - an age in which hospitals are no longer the preferred place to receive medical care. What has emerged is a strong support for alternative forms of health care delivery. One such form is ambulatory surgery (Detmeter, 1981).

Ambulatory surgery -- sometimes referred to as come-and-go surgery, in-and-out surgery and outpatient surgery -- is far from new. In England, between 1889 and 1909, more than 9,000 outpatient surgical procedures were successfully performed on ambulatory patients at the Royal Glasgow Hospital for Children. The concept was brought to the United States in 1918 when the first ambulatory surgery clinic was established in Sioux City, Iowa (Moxley III & Roeder, 1984). In 1938, Gertrude Herzfeld reported good results for outpatient pediatric hernia repairs performed under general anesthesia (Orman, 1979). Later, in 1945, Sholdice Hospital in Philadelphia began specializing in one-day hernia repairs. Despite these and other early successes, very little interest in ambulatory surgery existed in this country for many years.

It was the development of fast acting anesthetics in the 1960s that marked the real beginning for ambulatory surgery both inside and outside the hospital. In 1961, the Kaiser Permanente Medical Care Program in Portland, Oregon, treated 10 percent of its surgical patients on an outpatient basis

(Marks, 1980). However, it was not until 1968 that the first freestanding ambulatory surgical clinic was opened in Providence, Rhode Island. Then in 1970, Arizona followed Rhode Island with the opening of the first successful ambulatory surgery center in Phoenix. By February 1981 the Phoenix surgicenter had performed over 70,000 procedures (Moxley III & Roeder, 1984). Today, ambulatory surgery services are offered in over 1,500 facilities in the United States (Mauldin, 1984).

Why the sudden growth in ambulatory surgery? There are a number of recent health care trends that are responsible for this. Probably the most significant is the promotion of ambulatory surgery as a means of reducing health care costs. As early as 1981, Blue Cross and Blue Shield issued a policy statement promoting ambulatory surgery as a method of reducing surgical costs 30-50 percent (Curtin, 1984). Today the federal government, third party insurers and private industry have restructured reimbursement and benefit programs to encourage the use of ambulatory care facilities (Gilbert, 1983). These incentives have encouraged consumers to increase their use of these services.

Another factor that has contributed to the growth of ambulatory surgery has been the acceptance of alternative delivery systems by younger physicians. Physicians, traditionally gatekeepers of the health care system, are finding that their discretion to "freely" admit patients to hospitals is being eroded. More and more, the federal government, insurers, and industry are influencing where patients are treated. For example, Blue Cross and Blue Shield have published a list of operations that must be performed as outpatient procedures unless the patient has complications (Shanon, 1985). As a result, physicians have been pressured to experiment with alternative methods of health care delivery in order to prevent loss of income/patients. Physicians have begun

to compete for patients and dollars. Ambulatory surgery provides a mechanism that allows the physicians to effectively utilize their time and practice more efficiently by block scheduling patients for surgery (Drier, Winkle & Wetchler, 1984).

Consumers too are beginning to challenge the traditional, hospital based approach to health care delivery. The 1960s marked the beginning of a health conscious society that sought increased responsibility for their own health. The attitude of consumers toward life, and life styles has changed considerably. A majority of today's health care consumers are pressing for more community based health services that do not require time, separation or withdrawal from normal life activities (Moxley III & Roeder, 1984). Related to this movement is the growing insistence by consumers for information. The mass media, as well as government sponsored education programs have done much to create a more informed health care consumer. This new attitude by the consumer provides strong support for the increased use of ambulatory surgery.

Finally, a number of scientific and technological advances have made ambulatory surgical procedures safe for increasing segments of the population. While improvements in anesthetics has had the most dramatic impact on developing ambulatory surgery, other advances in both surgical techniques and instrumentation have increased the acceptance of ambulatory surgery as a viable alternative to inpatient surgery (Curtin, 1984).

Barriers to Developing Ambulatory Surgery

Although ambulatory surgery continues to grow, a number of factors have inhibited its growth. One of the major factors has been opposition from older/traditional physicians to new approaches for delivering care. Unfortunately, a small number of physicians are unwilling to consider changing their practice patterns and continue to admit patients to a hospital rather than

use ambulatory surgery. This resistance is often based on the fear of being sued. With the current emphasis on malpractice suits, this is a very important concern to physicians. The courts apply a standard of care rule in determining liability. Physicians in a small community which uses little ambulatory surgery often feel they run an increased risk of malpractice litigation should a complication occur. While this opinion is frequently cited in the literature, current studies indicate that many surgical procedures can be performed as safely in an ambulatory surgery setting as in a hospital setting (Natof, 1980; Nathanson, 1986).

Another factor which has impeded the development of ambulatory surgery services deals with patient resistance which stems from past experience and insurance considerations. A small number of patients continue to resist the physicians suggestion for ambulatory surgery because they know of a friend or relative that was hospitalized for the same surgical procedure and they reason they should also be hospitalized. Some patients feel that since they pay for their health care insurance, they are being cheated out of the care they deserve. However, more and more insurance companies and governmental agencies are restructuring their benefit programs to encourage the use of ambulatory surgery. For example, some insurance companies offer monetary rebates to patients who use outpatient surgery (Detmeter & Davidson, 1982).

Finally, hospitals have been reluctant to offer ambulatory surgery or increase the number of outpatient procedures they perform because of the potential reduction in hospital income. However, as the federal government, insurance companies and private industry continue to put pressure on health care prices, hospitals will be forced to increase the number of outpatient procedures. Otherwise, they risk the chance of losing both patients and income to alternate health care systems (Moxley III & Roeder, 1984).

Types of Facilities

The interest in ambulatory surgery has grown substantially during the past ten years. Numerous terms have been used to describe the types of Ambulatory Surgery Units that have been developed. However, outpatient facilities fall into three main categories: (1) surgical units found within a hospital but integrated with inpatient surgery; (2) Ambulatory Surgery Units found within a hospital but with independent facilities; and (3) the independent freestanding outpatient surgical unit (Detmer & Davidson, 1982).

The most common type of hospital based program is an integrated unit. An integrated program combines both inpatient and outpatient surgery in the same Operating Rooms. Characteristically, this type of program can be established with little capital investment and use present staff, facilities and support services. This type of program works well when: existing Operating Rooms have extra capacity, a low volume of patients is initially anticipated and minimal dollars can be expended by the hospital (Detmer & Davidson, 1982; O'Donovan, 1981).

A second type of hospital based facility is located within, or physically attached to the hospital, in which case separate, self-contained areas are provided within, or physically attached to the hospital. Characteristically, this type of facility has a separate registration area, a separate pre-op area, independent Operating Rooms and a self-contained postoperative area. This type of unit works well when: inpatient Operating Rooms are at maximum capacity, additional areas adjacent to inpatient Operating Rooms are unavailable and there is space available elsewhere in the hospital (Detmer & Davidson, 1982; O'Donovan, 1981).

Freestanding facilities are units physically separate from the other health care facilities. They may be independently, hospital or corporate-

owned facilities that were established as profit making enterprises. Free-standing surgical centers are designed and staffed only for the purpose of performing outpatient surgical procedures. There are two forms of free-standing facilities: freestanding on campus and freestanding off campus. Freestanding on campus facilities are located in separate facilities on the hospital grounds. Facilities of this type have a distinct identity from the hospital, do not compete for inpatient Operating Rooms or hospital space and are designed for ambulatory surgery patients. Freestanding on campus units work well when: there is a high projected volume of ambulatory surgery patients, a distinct identity from the hospital is desired, operating and capital dollars are available and a location can be found to adequately accommodate a new building. Freestanding off campus units are located in separate facilities off the hospital's grounds. Units of this type provide a new geographic area presence, a distinct identity from hospitals, no competition for inpatient Operating Rooms or hospital space and are specifically designed for ambulatory surgery patients. Freestanding off campus units work well when: a new geographic identity is desired, a young and growing population exists, operating and capital dollars are available and a site can be found that will accommodate the facility (Detmer & Davidson, 1982; O'Donovan, 1981).

Basic Goals of Ambulatory Surgery

Most ambulatory surgery programs are developed with three basic goals in mind. The first, patient convenience, is achieved by reducing the amount of time patients are away from their families. For surgical patients who do not require continuous postoperative observation and care that extends beyond the actual day of surgery, recovery at home is normally more convenient and agreeable to the patient. Often these patients resume their normal activities

sooner than inpatients with the same type surgery. Therefore, the whole event may be less traumatic and disruptive. Convenience to the physician is the second major goal. Ambulatory surgery typically provides for more efficient use of the physician's time, when compared with inpatient surgery. An effectively organized Ambulatory Surgery Unit has the potential of saving time and increasing convenience for physicians by using: a time specific surgical block, eliminating pre and postoperative in-hospital visits and by reducing the amount of paperwork since less extensive records may be acceptable for ambulatory surgery patients. Finally, reduced costs to the patient is a major goal in developing an effective ambulatory surgery program. The encouragement of ambulatory surgery is based largely on the expectation that the individual patient benefits from lower cost and a more appealing atmosphere if surgery can be done in a single day without a hospital admission. Because patients become ambulatory more rapidly, they need fewer drugs, laboratory tests and X-rays. This results in lower direct costs being passed on to the patient (Burns, 1984).

Future

Ambulatory surgery is increasing and will continue to increase. Changes in reimbursement policies to favor this service are still being made and the public is becoming more accustomed to the fact that health insurance will cover ambulatory surgery changes. The convenience factor and the cost containment aura associated with ambulatory surgery will continue to contribute to its growth.

III. DISCUSSION

Analysis of Current Operations

The present surgical treatment system exists entirely within the realm of traditional hospitalization. There is no formal preadmission testing program whereby the patient can accomplish most of the testing and administrative requirements before the actual day of hospitalization. Essentially, all major and minor surgical procedures are preceded by a day of hospitalization.

In order for an ambulatory surgery program to be effective, there must be a method of preadmitting the patient and completing the necessary testing prior to the actual day of surgery. To accomplish this, a preadmission surgical screening program for ambulatory surgery patients would have to be implemented. The Joint Commission on Accreditation of Hospitals (JCAH) states that, "when surgical services are provided in an ambulatory care setting, the policies and procedures shall be consistent with those applicable to inpatient surgery, anesthesia, and postoperative recovery" (JCAH, 1987).

MEDDAC Regulation 40-42 outlines the preoperative tests required for inpatients. It states that, "there are no routine diagnostic studies required prior to surgery". However, it recommends that all patients with an acute or chronic history of cardiopulmonary disease, including heavy cigarette abuse, and all patients over the age of 60 have a preoperative chest X-ray. An electrocardiogram (EKG) will be required before a major anesthetic is administered to any patient over forty years of age or to anyone with a history of cardiopulmonary disease. An EKG obtained six months prior to surgery for an asymptomatic patient, or within one month for a patient with a documented stable disease on stable therapy, will be acceptable. All other laboratory tests, e.g., CBC, urinalysis, electrolytes and clotting studies, should be

ordered on an individual basis and will not be used as screening tests. These standards, therefore, must be incorporated into the new policies and procedures for the Ambulatory Surgery Unit.

In order to gain both an historical perspective as to the type of surgical procedures that yield themselves as potential ambulatory surgery procedures and help access the impact of those procedures on the overall operation of the hospital, the Patient Administration Systems and Biostatistics Activity (PASBA) at Fort Sam Houston, Texas was contacted. PASBA provided an analysis of the short stay surgical admissions for FY 84, 85 and Jan-Jun 86. Records were selected based on the following criteria: direct admission (live births not included); type of disposition - to duty or discharges home; one surgery field coded for each inpatient with one or two bed days. Their study indicated that between 600 and 700 procedures were performed each year that could possibly be done on an ambulatory surgical basis. Although these procedures would require further analysis, they make up approximately 26 percent of the total number of surgeries currently performed in the main Operating Room at West Point. Based on these figures, PASBA calculated that approximately 11 percent of the total operating bed days would be free for other use if this workload was performed in an Ambulatory Surgery Unit.

Information Gathering

Rather than begin developing policies and procedures from scratch, contact with other healthcare organizations within the Army and West Point area was made in an attempt to obtain copies of their operating procedures. The staff at Madigan Army Medical Center, Walter Reed Army Medical Center, Putnam Hospital Center and St. Francis Hospital willingly responded with copies of their policies and procedures.

A review of the procedures currently being performed in each of the hospital-based ambulatory surgery programs revealed a large discrepancy in both the number and type of procedures done. For example, the list of approved procedures at Walter Reed Army Medical Center contains only 103 procedures (see Appendix A). Whereas, the list of approved procedures at Putnam Hospital Center has over 900 authorized procedures (see Appendix B). As one can readily see, both Department of Defense and civilian hospitals, with similar hospital-based ambulatory surgery programs, perform a myriad of procedures. Determining what procedures should be performed in an ambulatory surgery program is a major consideration in planning for and evaluating the feasibility of a program. The number and type of procedures are as varied as the institutions providing the service. To develop a comprehensive list of all the procedures performed would be a very lengthy process if not an impossible task since the number of surgical procedures approved varies from organization to organization. While there is some overlap in the type of procedures performed, the capabilities and limitations of each hospital must be reviewed when deciding which procedures should be performed on an ambulatory basis.

Rather than assuming all short-stay discharges would be candidates for ambulatory surgery, a listing provided by the Department of the Army was used as a base from which to identify possible ambulatory surgery procedures (see Appendix C). Although this list provided an initial starting point, a method had to be developed by which to identify those procedures currently being performed at West Point. Even though the Ambulatory Surgery Study performed by PASBA identified potential ambulatory surgery procedures, it could not be considered complete for two reasons. First, the list did not include the "total" number of procedures that could have been performed as ambulatory surgery. For example, if a procedure (Tonsillectomy with Adenoidectomy) was performed and

the patient hospitalized for three days it would not have been counted in their study. Second, the list did not discriminate as to the status, i.e., active duty, dependent, retired or cadet, of the patient. Both of these factors would be very important in accessing the impact of ambulatory surgery on MCCU production. Therefore, a complete list of surgical procedures was required in order to identify potential procedures. To obtain such a list, a program was developed and run through the Automated Quality Care Evaluation System (AQCESS). This generated a computer printout that identified all surgical procedures performed at West Point during the period 1 January 1986 to 30 June 1986. The printout listed each procedure according to: International Classification of Disease; patient's name; registration number; admitting date; discharge date and family member prefix. Once this had been completed, a comparison between the DOD list and AQCESS was performed in order to identify the number and type of procedures performed in the main Operating Rooms at West Point.

In order to further validate this list, a six month (1 Jan 86-30 Jun 86) retrospective analysis of the log books in the Operating Rooms and clinics was performed. The procedures were evaluated according to length of stay, frequency and Operating Room and recovery times. This provided a list of procedures which would not only qualify for inclusion into the hospital's program should one be implemented but provide a base from which to access the projected impact of ambulatory surgery on MCCU production (see Appendix D for detailed listing of procedures). Exclusion of a procedure from this list does not necessarily exclude it from being performed in the Ambulatory Surgery Unit. Appropriate procedures may be added to this list by each surgical speciality after having been approved by the Chief, Department of Surgery and the Chief of the requesting surgical service.

Interviews

The ultimate success of an ambulatory surgery program depends not only on the patients but the physicians who use the service. Professional staff acceptance of ambulatory surgery is extremely important to provide the patient source and to insure the continued high level of quality care. Personal interviews were therefore conducted with major department and service chiefs. The purpose of the interview was to elicit their personal and professional concepts, beliefs, ideas and criticisms concerning ambulatory surgery. On site visits and interviews were also conducted with appropriate staff members from two local hospitals that operate hospital-based ambulatory surgery programs.

Several interviews were conducted with the Chiefs of Surgery, Obstetrics and Gynecology, Department of Nursing, Anesthesiology, Orthopedics and General Surgery in order to elicit their personal opinions and provide a sounding board for their respective departments. Everyone in these interviews expressed a desire to initiate and participate in an ambulatory surgery program. The major objections concerned the location and staffing of the unit. Both concerns will be addressed later in this paper.

A personal interview was also conducted with Mrs. Haith, the Head Nurse in the main Recovery Room. Her opinion regarding ambulatory surgery would be extremely valuable since her unit would be responsible for providing care to these patients during the immediate postoperative period, but would not fully recover them to an ambulatory status. The problem is her area currently receives 110 to 130 cases per month and could not easily tolerate a group of ambulatory surgery patients with a prolonged stay. An initial recovery time of sixty to ninety minutes would not create a large problem, but to extend this to two or three hours would severely tax the quality of care provided by the Recovery Room.

In addition to the hospital staff, outside agencies in the surrounding areas were contacted in order to elicit their expertise in developing an ambulatory surgery program. Both hospitals were more than willing to provide information concerning the operation of their programs. Interviews with Mrs. Ginger Grace of St. Francis Hospital in Poughkeepsie, New York and Mrs. Margarette Price of Putnam Hospital Center proved to be very informative. Both facilities have hospital based ambulatory surgery programs whereby the Operating Rooms and Recovery Room are shared with the inpatient surgical services. As discussed in the literature review, this type of arrangement is very efficient in terms of resource allocation. However, both ladies were quick to point out that by not having a dedicated Operating Room for ambulatory surgery, their patients were bumped from the Operating Room schedule in lieu of inpatients and emergencies. Their recommendation was to have established day(s) dedicated for ambulatory surgery each week, i.e., Tuesday and Thursday.

Another point emphasized during both interviews was the need to have the patients' preoperative work completed prior to the actual day of surgery. Both felt that as much as 70 percent of their cancelled surgeries were due to the patient having incomplete preoperative work-ups, i.e., CBC missing or chest X-rays not filed in the patient's record. Their recommendation was to have the patient complete the testing the day they are notified of surgery or at least two or three days prior to coming in for surgery. By doing this, it allows time for the chart to be reviewed and actions taken to correct the problem before the day of surgery. Mrs. Grace went on to recommend that specific dates for preoperative testing be established. This would prevent the Anesthesiologist from being called out for anesthesia interviews randomly throughout the day.

The information obtained from this portion of the study must be kept in mind when developing policies and procedures for an ambulatory surgery program.

Physician Acceptance

In addition to interviewing Department Chiefs, a questionnaire was developed (see Appendix E) and distributed to the medical staff. The questionnaire was designed to obtain a broader scope of professional opinions than would be available through personal interviews. A total of twenty-nine questionnaires were distributed, and twenty-one were returned for a 73 percent return rate. Of those responding, 48 percent indicated they had experience working in a structured ambulatory surgery program. Of those who had experience, more than two-thirds said their experience was in a hospital-based, nondedicated unit. Without exception, all respondents stated they would participate in an ambulatory surgery program either by performing surgery or referring patients into the program. However, five percent of the physicians indicated that an ambulatory surgery program was not needed at Keller.

The key factor identified as inhibiting the establishment of an ambulatory surgery program appears to revolve around the staffing of the unit. As identified in HSC PAM 40-7-3, once the decision to implement an ambulatory surgery program has been made, a request for a change in the hospital's mission statement is required. If approved by Health Services Command (HSC), additional staffing requirements will be addressed based upon the information provided to them. Until the hospital receives the authorization from HSC for additional personnel, the hospital will have to operate the program using existing resources.

Patient Acceptance

The planning of an ambulatory surgery service must include consideration of the patient. After all, patients are not candidates for ambulatory surgery simply on the basis of the type of procedure to be performed or the fact that they are healthy. Many patients are unfamiliar with it and, therefore, may be apprehensive about participating in it. In order to access the attitude of the

beneficiary population at West Point toward ambulatory surgery, a patient survey was conducted. The questionnaire (see Appendix F) was randomly distributed to patients seen in the Orthopedic, Pediatric, Ophthalmology, Otolaryngology, Gynecology and General Surgery Clinics. A total of 150 questionnaires were distributed and 131 returned for an 87 percent response rate. The purpose of the survey was to elicit the patients personal experience, ideas and views concerning the proposed ambulatory surgery program.

The patient survey showed that almost 42 percent of the patients surveyed said that at least one member of their household had experienced ambulatory surgery. Of the households containing members who had experienced ambulatory surgery, 92 percent said they were satisfied with the type of treatment they received. Only 8 percent indicated their care was below average. The main reason for dissatisfaction with the level of care they received was that the staff either did not give them explanations of treatment or simply waited too long to give explanations. This type of complaint can be reduced or eliminated by hospital management. Nine percent of the respondents expressed a fear of being discharged too soon or not being able to get care once they returned home. This is a normal fear of the unknown and feelings about "what could happen" are certain to be experienced by the wary patient. However, this could be easily alleviated with a good pre and postoperative education program for the patient, with physician reassurance that they (the patient) will not be discharged until they are "ready" to go home and, that should an unforeseen problem arise, they can get the necessary treatment.

Demographically, there was no consistent pattern established by which to identify patients who are more likely to undergo ambulatory surgery. Of the 8 percent who indicated the care was below average, demographics was not deemed a factor for their dissatisfaction.

Without exception, 100 percent of the clients surveyed felt they would have no problem following the written preoperative and postoperative instructions or finding someone willing to provide them transportation to and from the hospital. However, 4 percent indicated that they did not have someone to take care of them once they were discharged from the hospital. Although the actual number is quite low, these patients would not qualify for ambulatory surgery.

Workload Analysis

Shifting surgical cases from the main Operating Rooms would impact on the hospital's workload. In order to access the impact of ambulatory surgery on workload accounting, an analysis of surgical procedures performed in both the Operating Rooms and as clinical procedures would be necessary.

The first phase of the workload analysis involved verifying those surgical cases performed in the main Operating Rooms that would qualify as potential ambulatory surgery procedures. Using the list of procedures identified at Appendix D and the computer printout from AQCESS, a complete list of potential ambulatory surgical patients admitted and discharged was developed. Although this provided an initial list of cases from which to access the projected impact of MCCUs, further evaluation of the family member prefix (FMP) was required. Those cases involving cadets, active duty and retired personnel who have no one to take care of them once discharged had to be identified and eliminated from the list. Consequently, a review of the patients' medical records was conducted. As a result, 206 surgical cases were identified as potential ambulatory surgery cases of which 73 percent or 151 cases involved only one or two bed days. Next, the total number of bed days generated by these cases were calculated and the totals added. The results of these calculations revealed that 454 bed days were generated from these cases. Therefore, the MCCUs generated from the 206 cases would be 2,514. What then

would be the impact on MCCUs if all 206 cases had been done on an ambulatory surgery basis? Using the same formula to calculate MCCUs, the total number of MCCUs produced would have been 2,266. Thus, for the period 1 January to 30 June 1987, the hospital would have experienced a net loss of 248 MCCUs if no replacement cases had been performed in the main Operating Room (see Appendix G for calculation of workload analysis).

The next phase of the workload analysis involved a review of the "minor" surgery files/log books in order to develop a list of potential ambulatory surgery procedures. Once these procedures were extracted, they had to be coded using the International Classification of Disease 9th Edition Clinical Modification coding system. As a result, three hundred and twelve procedures were identified as potential cases. These procedures were then reviewed by members of the surgical committee to ensure they were "valid" procedures for ambulatory surgery. It should be noted that some of the files/books maintained by the outpatient clinics were incomplete or missing. Consequently, the total number of cases identified as ambulatory surgery procedures does not reflect an accurate number of potential cases but represents a minimum estimate of the initial case load to be served.

Under the existing system, clinic procedures are weighted at .3 MCCUs per clinic visit. By counting these cases as outpatient visits, the hospital received only 94 MCCUs for their work. Whereas, had the patients been admitted and the surgery been performed in an Ambulatory Surgery Unit, the hospital would have received 11 MCCUs per case totaling 3,432 MCCUs. This would have resulted in a net gain of 3,338 MCCUs for the hospital (see Appendix H for calculation of Workload Analysis). During this period, January to June 1986, the hospital received $19.68 per MCCU. At this rate of reimbursement, the

hospital would have received $65,691.84. Thus, sufficient workload potential exists in the clinics to significantly increase MCCUs.

Based upon the preceding data, the overall effect of ambulatory surgery on productivity would have been a net gain of 3,083 MCCUs and a net gain in revenue of $60,673.44. However, this does not reflect the additional cost of having a Registered Nurse at $22,458 per year. Thus, the actual gain in revenue is only $38,215.44. Therefore, implementing an ambulatory surgery program would not result in a reduction of current surgical output but increase the total number of surgeries performed and subsequently increase the total number of MCCUs produced. This data does not reflect the potential increase in MCCUs had other surgical procedures been scheduled simultaneously in the main Operating Room. As this data shows, a patient population does exist within the hospital's area of responsibility to justify implementing an ambulatory surgery program.

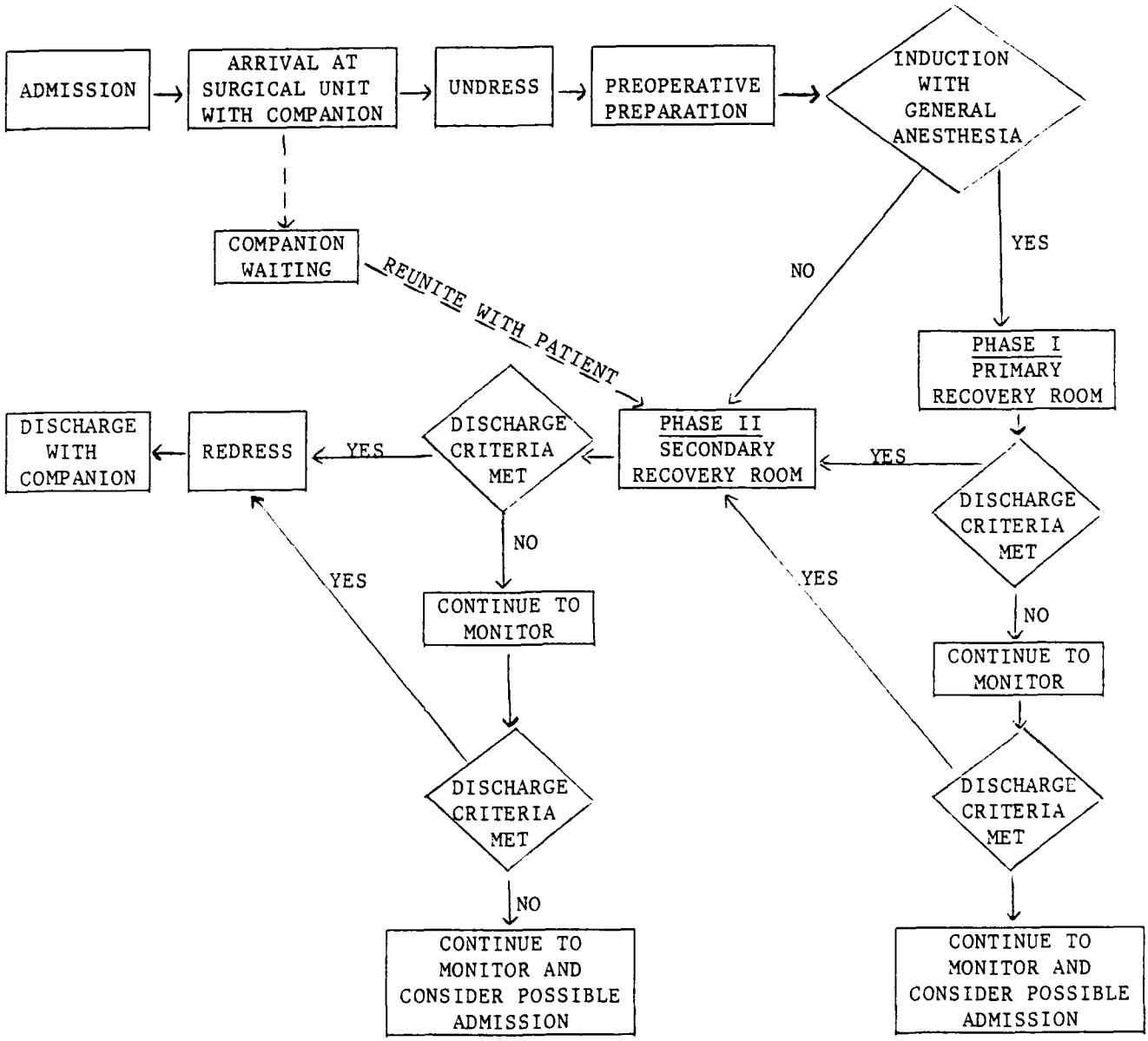
Site Selection

As one would expect, the only feasible type of ambulatory surgery program for Keller is a hospital affiliated unit. As described in the literature review, a program of this type can be established with little or no capital investment and use present staff, facilities and support services. As such, two viable alternatives exist at Keller for such a program. The first alternative is a hospital based, nondedicated unit. This type of program incorporates ambulatory surgery into both the existing inpatient Operating Rooms and post-anesthesia recovery schedule. The second alternative is a hospital based, defined unit. Under this concept, facilities are separate and distinct from those commonly used to care for general surgery patients. Such a unit has its own Operating Room but would remain dependent upon the main Recovery Room for patients requiring phase I recovery.

At the request of the Deputy Commander for Clinical Services (DCCS) an information paper addressing the advantages and disadvantages of each alternative was prepared and distributed to the DCCS; Chief, Department of Nursing; Chief, Patient Administration Division and the Chief, Clinical Support Division. This was done in order to elicit their ideas and personal opinions as to which program they felt Keller Army Hospital could support. The information obtained through their input was used in developing the decision paper presented to the Commander (see Appendix I).

Patient Flow Sequence

Once the site had been identified, the next step was to create a patient flow sequence for the ambulatory patient which would facilitate entry, treatment and discharge. The actual flow of patients through the Ambulatory Surgery Unit greatly influences the potential efficiency of the unit. The faster the patient moves through the unit, the less time they have to worry about their impending surgery. Flow should be smooth, rapid and as uneventful as is possible. Keeping this in mind, the following patient flow diagram was developed.



Actual patient flow through the Ambulatory Surgery Unit is shown at Appendix J.

Policies and Procedures

As with all new programs, guidelines must be developed which govern its operation. Although many policies and procedures need to be developed, only selected issues were addressed that pertained to the initial development of the ambulatory surgery program.

Using information obtained via the literature review, personal interviews, analysis of current operations and analysis of policies and procedures from other health care facilities, basic policies and procedures were developed governing the operation of the Ambulatory Surgery Unit. These policies and procedures are located in Appendixes K through S.

Implementation

In order for an ambulatory surgery program to be successful, the hospital must first implement a preadmission program for its ambulatory surgery patients. After all, preadmission testing is one of the basic criteria for a successful ambulatory surgery program. The concept of ambulatory surgery revolves around the idea of providing the easiest and fastest patient flow possible without jeopardizing the quality of care or patient safety. The completion of preadmission laboratory testing and administrative requirements must be accomplished and utilized to the fullest extent possible for ambulatory surgery patients in order that the day set aside for surgery is used for that service alone.

An Operating Room has 6 to 6½ hours of actual operating time for inpatients in each eight-hour shift. Using the day shift as a base line and assuming that the ambulatory surgical patients have their procedure completed by 1400 hours in order to recover and leave the facility by 1700 hours, fewer cases would be scheduled in the Operating Room than if the census were all inpatients. Based upon the preceding information, Keller could conceivably move four to five

patients per day through the Ambulatory Surgery Unit. Consequently, our program should begin operation two days a week which would be expanded once the program had time to get established.

Smooth and efficient scheduling is a must for any Operating Room environment; in an Ambulatory Surgery Unit it becomes even more critical to patient flow. The surgical schedule is a basis for planning, organizing, directing and controlling patient flow through the surgical experience. Based upon a review of the number and type of procedures performed at Keller, a combination of block scheduling and first-come, first-served scheduling would be best. The best features of both can be implemented to achieve the maximum efficiency for the unit. Block scheduling would satisfy the high volume user, Otolaryngology and Orthopedics; and first-come, first-served would make time available to the other clinics that do fewer procedures. A primary disadvantage of this would be finding the right proportions of block and first-come, first-served scheduling. One method of overcoming this is by blocking the first part of the day for a specific surgeon with the remainder of the time scheduled on a first-come, first-served basis.

As the literature indicates, the success and failure of an ambulatory surgery program depends not only on the attitude of the hospital staff but the program's acceptance by the beneficiary population (Burns, 1984; Detmer & Davidson, 1982). Although this study indicates that both the physicians and patients are willing to accept ambulatory surgery as a viable healthcare option, further "education" is necessary in order to increase the effective utilization of the Ambulatory Surgery Unit. Keeping this and the preceding information in mind an implementation plan was developed (see Appendix T).

IV. CONCLUSION

As noted in the literature review, ambulatory surgery in the civilian health care system has been accepted as an alternate method of health care delivery. It has only been within the last year that the Department of Defense (DOD) has begun to explore the idea of implementing ambulatory surgery within the military health care system. A survey conducted by the Government Accounting Office (GAO) in 1985 found that only 5 of the 169 hospitals in the military health care system had formal programs for ambulatory surgery (Army Times, September 1986). The move toward ambulatory surgery, by the military, is expected to reduce hospital stays for service members and their dependents and increase the number of inpatient beds for more serious illnesses.

The concept of an ambulatory surgery program at West Point is both feasible and desirable for several reasons. First, the hospital can establish a program with little capital investment and, with the exception of hiring one additional Registered Nurse, use present staff, facilities and support services. In addition, the hospital can make more efficient use of its resources. Removing the minor surgical from the main Operating Rooms not only means a decreased waiting time for inpatient surgery and a considerable increase in the turnover of minor cases, but that more beds would be available on the Medical Surgical Unit (MSU) to treat patients with more serious problems. According to the Chief, Department of Nursing, this would make the ward easier to operate, since those patients who are likely to remain in the hospital for a number of days or weeks place less of a burden on the ward staff than the daily influx of minor one- or two-day admissions. Additionally, by channeling those procedures currently being performed in the Operating Rooms and Clinics into an Ambulatory Surgery Unit, the hospital would recognize a substantial increase in both productivity and revenue.

Second, as the patient questionnaire indicates, the beneficiary population at West Point supports the concept of an ambulatory surgery program. From the patient's perspective there are many advantages to having ambulatory surgery performed. For the patient having minor surgery, most of the time spent in the hospital is as a "hotel" guest, requiring neither skilled medical or nursing care. By having ambulatory surgery performed, the patient benefits psychologically by being able to spend most of the preoperative and postoperative periods at home with a minimum of disruption in his/her daily life. Unlike the civilian sector, the actual cost or savings associated with inpatient hospitalization is not a major factor in determining where or how surgery will be performed since the "bill" is paid by the government. However, since ambulatory surgery would eliminate the pre- and postoperative stay in the hospital, the dependent and retired population could potentially reduce the amount of time they are away from their job, thereby recognizing a savings in both time and money.

Finally, the physician response to an ambulatory program was very positive. By implementing an ambulatory surgery program at Keller, more efficient use of the physician's time could be realized by using time-specific surgical blocks for ambulatory surgery thus allowing more time in the clinics by elimination of pre- and postoperative inpatient hospital visits and by reducing the amount of paperwork required for admission.

Therefore, based upon the preceding discussion, ambulatory Surgery is a viable alternative form of health care delivery at West Point.

APPENDIX A

PROCEDURES CONSIDERED ACCEPTABLE FOR AMBULATORY SURGERY AT WALTER REED ARMY MEDICAL CENTER

PROCEDURE

Otolaryngology

1. Myringotomy (with or without insertion of PE tubes)
2. Removal of PE tubes
3. Septorhinoplasties
4. Nasal polypectomies
5. Maxillary antrostomies and antral windows
6. Closed reduction and fixation of nasal fractures
7. Small scar revisions of head and neck
8. Diagnostic and therapeutic endoscopies
9. Type I tympanoplasties
10. Closed reduction of zygomatic arch (towel clip technique)
11. Frenotomy
12. Excision aural polyp
13. Adenoidectomy
14. Tonsillectomy
15. Biopsy of tongue

Plastic

1. Augmentation mammoplasty
2. Rhinoplasty
3. Minor scar revisions
4. Suture removal on children
5. Minor procedures on children requiring general anesthesia
6. Otoplasty
7. Cheiloplasty

Oral Surgery

1. Complicated exodontia (adult and pediatric)
2. Surgical removal of odontogenic and nonodontogenic lesions
3. Closed reduction of facial fractures

Orthopedics

1. Closed reduction of simple fractures
2. Percutaneous pin fixation of fractures
3. Carpal tunnel release
4. Extensor tendon release
5. Tenosynovectomy, finger
6. Muscle biopsies
7. Shoulder, hip and knee manipulation
8. Cast change
9. Pin and wire removal
10. Removal foreign body in muscle, simple
11. Bunionectomy
12. Synovial biopsy
13. Diagnostic arthroscopy
14. Faciotomy, palmar for DePuytrene's contracture
15. Ganglion excision

Orthopedics continued

16. Tenotomy
17. Excision Morton's neuroma
18. Arthroscopic meniscectomy
19. Digital neurorrhaphy

Genitourinary

1. Circumcision
2. Orchiopexy
3. Vasectomy
4. Vasovasectomies

Thoracic

1. Rigid bronchoscopy
2. Rigid esophagoscopy
3. Esophageal dilation (primarily in children)
4. Removal of sternal wires or other appliances in ASA Class I and II
5. Debridement of chest wall sites not requiring hospitalization

Obstetrics and Gynecology

1. Elective sterilization
2. Diagnostic minilaparotomies
3. D&C
4. EUA
5. Removal of IUD
6. Diagnostic laparoscopies
7. Biopsy of perineum
8. Hymenectomy
9. Vaginal dilation
10. Hysteroscopy

Ophthalmology

1. Strabismus surgery
2. EUA
3. Lacrimal duct probing
4. Cyclocryotherapy
5. Retinal cryopexy
6. Photocoagulation
7. Minor lid procedures
8. Blepharoplasty
9. Chalazion removal
10. Ptosis procedures
11. Pterygium removal
12. Cataract removal

General Surgery

1. Hernia repair (adult and pediatrics)
2. Excisional biopsies

General Surgery continued

3. Gastroscopy (pediatric)
4. Superficial and integumentary lesions
5. Sigmoidoscopy (pediatric)
6. Orchiopexy
7. Frenulectomy
8. Anal and rectal biopsies
9. Node biopsies
10. Examination under anesthesia
11. Breast biopsy (2 stage procedure)
12. Breast biopsy (needle localization)
13. Rectal polypectomy
14. Excision sebaceous cyst
15. Drainage of simple hematoma
16. Arterial puncture on children
17. Esophagoscopy
18. Gastroscopy
19. Fistulotomy, subcutaneous
20. Fistulectomy
21. Hemorrhoidectomy, simple ligature
22. Aspirational biopsies
23. Pilonidal cyst

Neurosurgery

1. Carpal tunnel release
2. Skull biopsises
3. Excision Morton's neuroma
4. Ulnar nerve transposition

APPENDIX B

PROCEDURES CONSIDERED ACCEPTABLE

IN THE AMBULATORY SURGERY UNIT AT PUTNAM HOSPITAL CENTER,

ST. FRANCIS HOSPITAL, CARMEL, NEW YORK

EMPIRE BLUE CROSS AND BLUE SHIELD
NEW YORK DIVISION
AMBULATORY SURGERY PROGRAM
1986 LIST

NERVOUS SYSTEM (01-05)

* 01.01 Cisternal puncture (tap)
* 01.15 Biopsy of skull

02.94 Insertion or replacement of skull tongs or halo traction device
* 02.95 Removal of skull tongs or halo traction device

* 03.31 Spinal tap
* 03.8 Injection of destructive agent into spinal canal
* 03.91 Injection of anesthetic into spinal canal for analgesia
03.92 Injection of other agent into spinal canal
* 03.96 Percutaneous denervation of facet

* 04.04 Other incision of cranial and peripheral nerves
* 04.06 Other cranial or peripheral ganglionectomy
04.07 Other excision or avulsion of cranial and peripheral nerves
Curettage, debridement, resection or excision of peripheral nerve; Excision of peripheral neuroma (Morton's)
* 04.11 Percutaneous biopsy of cranial or peripheral nerve or ganglion
* 04.12 Other biopsy of cranial or peripheral nerve or ganglion
04.2 Destruction of cranial and peripheral nerves
Destruction of cranial or peripheral nerves by injection of neurolytic agent
04.3 Suture of cranial and peripheral nerves
04.43 Release of carpal tunnel
04.44 Release of tarsal tunnel
* 04.49 Other peripheral nerve or ganglion decompression or lysis of adhesions
Peripheral nerve neurolysis NOS
* 04.92 Implantation or replacement of peripheral neurostimulator

ENDOCRINE SYSTEM (06-07)

* 07.11 Percutaneous (needle) biopsy of adrenal gland

EYE (08-16)

08.02 Severing of blepharorrhaphy
* 08.23 Excision of major lesion of eyelid, partial-thickness
08.24 Excision of major lesion of eyelid, full-thickness
08.31 Repair of blepharoptosis by frontalis muscle technique with suture
08.32 Repair of blepharoptosis by frontalis muscle technique with fascial sling
08.33 Repair of blepharoptosis by resection or advancement of levator muscle or aponeurosis
08.34 Repair of blepharoptosis by other levator muscle techniques
08.35 Repair of blepharoptosis by tarsal technique
08.36 Repair of blepharoptosis by other techniques
08.37 Reduction of overcorrection of ptosis
08.38 Correction of lid retraction

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EYE continued

	08.41	Repair of entropion or ectropion by thermocauterization
	08.42	Repair of entropion or ectropion by suture technique
	08.43	Repair of entropion or ectropion with wedge resection
	08.44	Repair of entropion or ectropion with lid reconstruction
	08.49	Other repair of entropion or ectropion
	08.52	Blepharorrhaphy Canthorrhaphy; Tarsorrhaphy
*	08.59	Other (adjustment of lid position) Canthoplasty NOS; Repair of epicanthal fold
	08.61	Reconstruction of eyelid with skin flap or graft
	08.62	Reconstruction of eyelid with mucous membrane flap or graft
	08.63	Reconstruction of eyelid with hair follicle graft
	08.64	Reconstruction of eyelid with tarsoconjunctival flap
	08.69	Other reconstruction of eyelid with flaps or grafts
	08.70	Reconstruction of eyelid, not otherwise specified
	08.71	Reconstruction of eyelid involving lid margin, partial-thickness
	08.72	Other reconstruction of eyelid, partial-thickness
	08.73	Reconstruction of eyelid involving lid margin, full-thickness
	08.74	Other reconstruction of eyelid, full-thickness
*	08.81	Linear repair of laceration of eyelid or eyebrow
*	08.82	Repair of laceration involving lid margin, partial-thickness
*	08.83	Other repair of laceration of eyelid, partial-thickness
*	08.84	Repair of laceration involving lid margin, full-thickness
*	08.85	Other repair of laceration of eyelid, full-thickness
	08.86	Lower eyelid rhytidectomy
	08.87	Upper eyelid rhytidectomy
*	09.11	Biopsy of lacrimal gland
*	09.12	Biopsy of lacrimal sac
*	09.20	Excision of lacrimal gland, not otherwise specified
*	09.21	Excision of lesion of lacrimal gland
*	09.22	Other partial dacryoadenectomy
*	09.23	Total dacryoadenectomy
*	09.44	Intubation of nasolacrimal duct Insertion of stent into nasolacrimal duct
	09.51	Incision of lacrimal punctum
*	09.52	Incision of lacrimal canaliculi
	09.53	Incision of lacrimal sac
*	09.59	Other incision of lacrimal passages
*	09.71	Correction of everted punctum
*	09.72	Other repair of punctum
*	09.73	Repair of canaliculus
*	09.81	Dacryocystorhinostomy (DCR)
*	09.82	Conjunctivocystorhinostomy Conjunctivodacryocystorhinostomy (CDCR)
*	09.83	Conjunctivorhinostomy with insertion of tube or stent
*	09.91	Obliteration of lacrimal punctum
*	10.21	Biopsy of conjunctiva
*	10.31	Excision of lesion or tissue of conjunctiva
	10.32	Destruction of lesion of conjunctiva

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EYE continued

*	10.33	Other destructive procedures on conjunctiva Removal of trachoma follicles
	10.41	Repair of symblepharon with free graft
	10.42	Reconstruction of conjunctival cul-de-sac with free graft
	10.43	Other reconstruction of conjunctival cul-de-sac
	10.44	Other free graft to conjunctiva
	10.49	Other conjunctivoplasty
*	10.5	Lysis of adhesions of conjunctiva and eyelid Division of symblepharon (with insertion of conformer)
*	11.1	Incision of cornea
*	11.22	Biopsy of cornea
	11.31	Transposition of pterygium
	11.32	Excision of pterygium with corneal graft
	11.39	Other excision of pterygium
*	11.42	Thermocauterization of corneal lesion
*	11.43	Cryotherapy of corneal lesion
*	11.51	Suture of corneal laceration
*	11.52	Repair of postoperative wound dehiscence of cornea
*	11.53	Repair of corneal laceration or wound with conjunctival flap
	11.59	Other repair of cornea
*	11.60	Corneal transplant, not otherwise specified Keratoplasty (NOS)
*	11.61	Lamellar keratoplasty with autograft
*	11.62	Other lamellar keratoplasty
	11.63	Penetrating keratoplasty with autograft
	11.64	Other penetrating keratoplasty
*	11.69	Other corneal transplant
*	11.71	Keratomeleusis
*	11.72	Keratophakia
*	11.74	Thermokeratoplasty
*	11.91	Tattooing of cornea
*	11.92	Removal of artificial implant from cornea
*	12.00	Removal of intraocular foreign body from anterior segment of eye, not otherwise specified
*	12.01	Removal of intraocular foreign body from anterior segment of eye with use of magnet
*	12.02	Removal of intraocular foreign body from anterior segment of eye without use of magnet
*	12.11	Iridotomy with transfixion
	12.12	Other iridotomy
*	12.13	Excision of prolapsed iris
	12.14	Other iridectomy
*	12.21	Diagnostic aspiration of anterior chamber of eye
*	12.22	Biopsy of iris
*	12.31	Lysis of goniosynechiae
*	12.32	Lysis of other anterior synechiae
*	12.33	Lysis of posterior synechiae
*	12.34	Lysis of corneovitreal adhesions
*	12.35	Coreoplasty Needling of pupillary membrane

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EYE continued

*	12.39	Other iridoplasty
	12.42	Excision of lesion of iris
*	12.44	Excision of lesion of ciliary body
*	12.51	Goniopuncture without goniotomy
*	12.52	Goniotomy without goniopuncture
*	12.53	Goniotomy with goniopuncture
*	12.54	Trabeculotomy ab externo
	12.55	Cyclodialysis
	12.59	Other facilitation of intraocular circulation-
*	12.61	Trephination of sclera with iridectomy
*	12.62	Thermocauterization of sclera with iridectomy
*	12.63	Iridencleisis and iridotasis
	12.64	Trabeculectomy ab externo
*	12.65	Other scleral fistulization with iridectomy
*	12.66	Postoperative revision of scleral fistulization procedure Revision of filtering bleb
*	12.69	Other fistulizing procedure
*	12.71	Cyclodiathermy
*	12.72	Cyclocryotherapy
*	12.81	Suture of laceration of sclera
*	12.82	Repair of scleral fistula
*	12.83	Revision of operative wound of anterior segment, not elsewhere classified
*	12.85	Repair of scleral staphyloma with graft
*	12.86	Other repair of scleral staphyloma
*	12.87	Scleral reinforcement with graft
	12.88	Other scleral reinforcement
	12.89	Other operations on sclera Exploratory sclerotomy
	12.91	Therapeutic evacuation of anterior chamber (Paracentesis)
*	13.00	Removal of foreign body from lens, not otherwise specified
*	13.01	Removal of foreign body from lens with use of magnet
*	13.02	Removal of foreign body from lens without use of magnet
*	13.11	Intracapsular extraction of lens by temporal inferior route
	13.19	Other intracapsular extraction of lens
	13.2	Extracapsular extraction of lens by linear extraction technique
*	13.3	Extracapsular extraction of lens by simple aspiration (and irrigation) technique
*	13.41	Phacoemulsification and aspiration of cataract
*	13.42	Mechanical phacofragmentation and aspiration of cataract by posterior route
*	13.43	Mechanical phacofragmentation and other aspiration of cataract
*	13.51	Extracapsular extraction of lens by temporal inferior route
*	13.59	Other extracapsular extraction of lens
*	13.61	Discission of primary membranous cataract
*	13.62	Excision of primary membranous cataract
*	13.63	Mechanical fragmentation of primary membranous cataract
	13.64	Discission of secondary membrane (after cataract)
	13.65	Excision of secondary membrane (after cataract)
*	13.66	Mechanical fragmentation of secondary membrane (after cataract)
*	13.69	Other cataract extraction
*	13.70	Insertion of pseudophakos, not otherwise specified
	13.71	Insertion of intraocular lens prosthesis at time of cataract extraction, one-stage

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EYE continued

	13.72	Secondary insertion of intraocular lens prosthesis
	13.8	Removal of implanted lens (pseudophakos)
*	14.00	Removal of foreign body from posterior segment of eye, not otherwise specified
*	14.01	Removal of foreign body from posterior segment of eye with use of magnet
*	14.02	Removal of foreign body from posterior segment of eye without use of magnet
*	14.11	Diagnostic aspiration of vitreous
*	14.21	Destruction of chorioretinal lesion by diathermy
*	14.22	Destruction of chorioretinal lesion by cryotherapy
*	14.27	Destruction of chorioretinal lesion by implantation of radiation source
*	14.31	Repair of retinal tear by diathermy
	14.32	Repair of retinal tear by cryotherapy
	14.41	Scleral buckling with implant
	14.49	Other scleral buckling
	14.51	Repair of retinal detachment with diathermy
	14.52	Repair of retinal detachment with cryotherapy
	14.53	Repair of retinal detachment with xenon arc photocoagulation
	14.54	Repair of retinal detachment with laser photocoagulation
	14.55	Repair of retinal detachment with photocoagulation of unspecified type
*	14.71	Removal of vitreous, anterior approach
	14.72	Other removal of vitreous Aspiration of vitreous by posterior sclerotomy
*	14.73	Mechanical vitrectomy by anterior approach
*	14.74	Other mechanical vitrectomy
*	14.75	Injection of vitreous substitute
*	15.01	Biopsy of extraocular muscle or tendon
	15.11	Recession of one extraocular muscle
	15.12	Advancement of one extraocular muscle
	15.13	Resection of one extraocular muscle
	15.19	Other operations on one extraocular muscle involving temporary detachment from globe
	15.21	Lengthening procedure on one extraocular muscle
	15.22	Shortening procedure on one extraocular muscle
	15.29	Other (Operations on one extraocular muscle)
	15.3	Operations on two or more extraocular muscles involving temporary detachment from globe, one or both eyes
*	15.4	Other operations on two or more extraocular muscles, one or both eyes
*	15.5	Transposition of extraocular muscles
*	15.6	Revision of extraocular muscle surgery
*	15.7	Repair of injury of extraocular muscle
*	15.9	Other operations on extraocular muscles and tendons
*	16.23	Biopsy of eyeball and orbit
*	16.81	Repair of wound of orbit
*	16.92	Excision of lesion of orbit

EAR (18-20)

*	18.21	Excision of preauricular sinus
	18.31	Radical excision of lesion of external ear
	18.5	Surgical correction of prominent ear

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EAR continued

	18.6	Reconstruction of external auditory canal
*	18.79	Other plastic repair of external ear Otoplasty; Postauricular skin graft; Repair of lop ear
	19.4	Myringoplasty Epitympanic, type I; Myringoplasty by cauterization, graft; Tympanoplasty (type I)
*	19.6	Revision of tympanoplasty
*	20.32	Biopsy of middle and inner ear
*	20.51	Excision of lesion of middle ear
*	20.8	Operations on Eustachian tube Injection (Teflon paste)

NOSE, MOUTH AND PHARYNX (21-29)

*	21.4	Resection of nose
	21.5	Submucous resection of nasal septum
	21.61	Turbinectomy by diathermy or cryosurgery
*	21.62	Fracture of the turbinates
	21.69	Other turbinectomy
*	21.72	Open reduction of nasal fracture
	21.82	Closure of nasal fistula Nasolabial, Nasopharyngeal, Oronasal fistulectomy
	21.84	Revision rhinoplasty
	21.85	Augmentation rhinoplasty
*	21.86	Limited rhinoplasty
	21.87	Other rhinoplasty
	21.88	Other septoplasty
	22.2	Intranasal antrotomy
*	22.39	Other external maxillary antrotomy Exploration of maxillary antrum with Caldwell-Luc approach
*	22.50	Sinusotomy, not otherwise specified
	22.60	Sinusectomy, not otherwise specified
*	22.71	Closure of nasal sinus fistula
*	22.79	Other repair of nasal sinus
*	25.1	Excision or destruction of lesion or tissue of tongue
*	25.2	Partial glossectomy
*	25.59	Other repair and plastic operations on tongue Fascial sling of tongue; Fusion of tongue (to lip); Graft of mucosa or skin to tongue
*	25.93	Lysis of adhesions of tongue
	26.0	Incision of salivary gland or duct
*	26.11	Biopsy of salivary gland or duct
*	26.21	Marsupialization of salivary gland cyst
*	26.29	Other excision of salivary gland lesion
*	26.42	Closure of salivary fistula
	26.49	Other repair and plastic operations on salivary gland or duct
	27.0	Drainage of face and floor of mouth (Ludwig's Angina)

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NOSE, MOUTH, AND PHARYNX continued

*	27.21	Biopsy of bony palate
*	27.31	Local excision or destruction of lesion or tissue of bony palate
	27.42	Wide excision of lesion of lip
*	27.53	Closure of fistula of mouth
*	27.54	Repair of cleft lip
*	27.55	Full-thickness skin graft to lip and mouth
*	27.56	Other skin graft to lip and mouth
*	27.57	Attachment of pedicle or flap graft to lip and mouth
*	27.62	Correction of cleft palate
*	27.63	Revision of cleft palate repair
*	27.69	Other plastic repair of palate
*	27.73	Repair of uvula
*	27.99	Other operations on oral cavity Graft of buccal sulcus
	28.2	Tonsillectomy without adenoidectomy
	28.3	Tonsillectomy with adenoidectomy
	28.5	Excision of lingual tonsil
	28.6	Adenoidectomy without tonsillectomy
*	28.91	Removal of foreign body from tonsil and adenoid by incision
*	28.92	Excision of lesion of tonsil and adenoid
*	29.12	Pharyngeal biopsy
*	29.3	Excision or destruction of lesion or tissue of pharynx
*	29.53	Closure of other fistula of pharynx
*	29.54	Lysis of pharyngeal adhesions
*	29.92	Division of glossopharyngeal nerve

RESPIRATORY SYSTEM (30-34)

	30.09	Other excision or destruction of lesion or tissue of larynx Stripping of vocal cords
	31.43	Biopsy of larynx
*	31.44	Biopsy of trachea
	33.22	Fiber-optic bronchoscopy
	33.23	Other bronchoscopy
	33.24	Endoscopic bronchial biopsy
	33.25	Other biopsy of bronchus
*	33.26	Percutaneous (needle) biopsy of lung
*	33.27	Other biopsy of lung
*	33.91	Bronchial dilation
*	34.21	Transpleural thoracoscopy
	34.23	Biopsy of chest wall
	34.24	Pleural biopsy
*	34.25	Percutaneous (needle) biopsy of mediastinum
*	34.91	Thoracentesis

CARDIOVASCULAR SYSTEM (35-39)

	37.21	Right heart cardiac catheterization
*	37.22	Left heart cardiac catheterization

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CARDIOVASCULAR SYSTEM continued

	37.23	Combined right and left heart cardiac catheterization
*	37.70	Insertion of cardiac pacemaker, not otherwise specified
*	37.71	Insertion of temporary pacemaker into ventricle
	37.72	Insertion of temporary cardiac pacemaker into other and unspecified site
*	37.73	Insertion of permanent pacemaker into atrium, transvenous route
*	37.74	Insertion of permanent pacemaker into ventricle, transvenous route
*	37.75	Insertion of permanent cardiac pacemaker into unspecified site, transvenous rou
*	37.77	Insertion of permanent cardiac pacemaker, unspecified approach
*	37.81	Replacement of transvenous electrode
*	37.82	Replacement of epicardial electrode
*	37.83	Removal of transvenous electrode
*	37.84	Removal of epicardial electrode
*	37.85	Replacement of cardiac pacemaker pulse generator (battery)
*	37.86	Removal of cardiac pacemaker system (temporary)
*	37.89	Other revision of cardiac pacemaker system
		Incision of vessel for codes:
*	38.00	Unspecified site
*	38.03	Upper limb vessels
*	38.08	Lower limb arteries
*	38.09	Lower limb veins
	38.21	Biopsy of blood vessel
		Ligation and stripping of varicose veins for codes:
*	38.50	Unspecified site
*	38.53	Upper limb vessels
*	38.57	Abdominal veins
	38.59	Lower limb veins
		Other excision of vessel for codes:
*	38.60	Unspecified site
*	38.63	Upper limb vessels
*	38.68	Lower limb arteries
	38.69	Lower limb veins
		Other surgical occlusion of vessels for codes:
	38.80	Unspecified site
*	38.83	Upper limb vessels
	38.88	Lower limb arteries
	38.89	Lower limb veins
	38.91	Arterial catheterization
*	38.92	Umbilical vein catheterization
	39.27	Arteriovenostomy for renal dialysis
*	39.42	Revision of arteriovenous shunt for renal dialysis
*	39.43	Removal of arteriovenous shunt for renal dialysis
*	39.49	Other revision of vascular procedure
*	39.91	Freeing of vessel
*	39.93	Insertion of vessel-to-vessel cannula
*	39.94	Replacement of vessel-to-vessel cannula

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HEMIC AND LYMPHATIC SYSTEM (40-41)

	40.11	Biopsy of lymphatic structure
	40.21	Excision of deep cervical lymph node
	40.22	Excision of internal mammary lymph node
	40.23	Excision of axillary lymph node
	40.24	Excision of inguinal lymph node
	40.29	Simple excision of other lymphatic structure
*	40.9	Other operations on lymphatic structures
*	41.91	Aspiration of bone marrow from donor for transplant

DIGESTIVE SYSTEM (42-54)

	42.23	Other esophagoscopy
	42.24	Biopsy of esophagus
*	42.31	Local excision of esophageal diverticulum
	42.32	Local excision of other lesion or tissue of esophagus
*	42.39	Other destruction of lesion or tissue of esophagus
	42.92	Dilation of esophagus
	43.41	Gastric polypectomy
	43.42	Local excision of other lesion or tissue of stomach
*	43.49	Other destruction of lesion or tissue of stomach
	44.13	Other gastroscopy
*	44.14	Brush biopsy of stomach
	44.15	Other biopsy of stomach
	45.13	Other endoscopy of small intestine
*	45.14	Brush biopsy of small intestine
	45.15	Other biopsy of small intestine
	45.23	Flexible fiberoptic colonoscopy
	45.31	Local excision of lesion of duodenum
*	45.32	Other destruction of lesion of duodenum
*	45.33	Local excision of lesion or tissue of small intestine, except duodenum Excision of redundant mucosa of ileostomy
*	45.34	Other destruction of lesion of small intestine, except duodenum
*	48.31	Radical electrocoagulation of rectal lesion or tissue
*	48.79	Other repair of rectum Repair of old obstetric laceration of rectum
*	48.91	Incision of rectal stricture
*	49.11	Anal fistulotomy
	49.12	Anal fistulectomy
*	49.43	Cauterization of hemorrhoids
	49.44	Destruction of hemorrhoids by cryotherapy
	49.45	Ligation of hemorrhoids
	49.46	Excision of hemorrhoids
*	49.51	Left lateral anal sphincterotomy
*	49.52	Posterior anal sphincterotomy
	49.59	Other anal sphincterotomy
*	49.72	Anal cerclage
	49.73	Closure of anal fistula

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DIGESTIVE SYSTEM continued

	49.79	Other repair of anal sphincter Repair of old obstetrical laceration of anus
*	49.91	Incision of anal septum
*	49.92	Insertion of subcutaneous electrical anal stimulator
*	49.93	Other incision of anus
	50.11	Percutaneous (needle) biopsy of liver
*	50.91	Percutaneous aspiration of liver
*	51.11	Endoscopy of biliary tract
*	51.96	Percutaneous extraction of common duct stones
*	52.91	Endoscopic retrograde cannulation of pancreatic duct (ERCP)
*	53	Repair of hernia
	53.00	Unilateral repair of inguinal hernia, not otherwise specified
	53.01	Repair of direct inguinal hernia
	53.02	Repair of indirect inguinal hernia
	53.03	Repair of direct inguinal hernia with graft or prosthesis
	53.04	Repair of indirect inguinal hernia with graft or prosthesis
	53.05	Repair of inguinal hernia with graft or prosthesis, not otherwise specified
	53.10	Bilateral repair of inguinal hernia, not otherwise specified
*	53.11	Bilateral repair of direct inguinal hernia
*	53.12	Bilateral repair of indirect inguinal hernia
*	53.13	Bilateral repair of inguinal hernia, one direct and one indirect
	53.14	Bilateral repair of direct inguinal hernia with graft or prosthesis
*	53.15	Bilateral repair of indirect inguinal hernia with graft or prosthesis
*	53.16	Bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis
*	53.17	Bilateral inguinal hernia repair with graft or prosthesis, not otherwise specified
*	53.21	Unilateral repair of femoral hernia with graft or prosthesis
*	53.29	Other unilateral femoral herniorrhaphy
*	53.31	Bilateral repair of femoral hernia with graft or prosthesis
*	53.39	Other bilateral femoral herniorrhaphy
*	53.41	Repair of umbilical hernia with prosthesis
*	53.49	Other umbilical herniorrhaphy
*	53.51	Incisional hernia repair
*	53.59	Repair of other hernia of anterior abdominal wall
*	53.61	Incisional hernia repair with prosthesis
	54.21	Laparoscopy (Peritoneoscopy)
*	54.22	Biopsy of abdominal wall or umbilicus
	54.23	Biopsy of peritoneum
*	54.3	Excision or destruction of lesion or tissue of abdominal wall or umbilicus
	54.91	Percutaneous abdominal paracentesis
*	54.95	Incision of peritoneum
*	54.96	Injection of air into peritoneal cavity

URINARY SYSTEM (55-59)

	55.02	Nephrostomy
*	55.12	Pyelostomy

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URINARY SYSTEM continued

	55.21	Nephroscopy
*	55.22	Pyeloscopy
	55.23	Percutaneous (needle) biopsy of kidney
*	55.24	Other biopsy of kidney
*	55.92	Percutaneous aspiration of kidney (pelvis) Aspiration of renal cyst
*	55.93	Replacement of nephrostomy tube
*	55.94	Replacement of pyelostomy tube
*	56.0	Transurethral removal of obstruction from ureter and renal pelvis
*	56.1	Ureteral meatotomy
*	56.31	Ureteroscopy
*	56.81	Lysis of intraluminal adhesions of ureter
*	56.91	Dilation of ureteral meatus
*	57.0	Transurethral clearance of bladder
*	57.11	Percutaneous aspiration of bladder
	57.31	Cystoscopy through artificial stoma
	57.32	Other cystoscopy (Transurethral)
*	57.33	Transurethral biopsy of bladder
	57.34	Other biopsy of bladder
*	57.41	Transurethral lysis of intraluminal adhesions
	57.49	Other transurethral excision or destruction of lesion or tissue of bladder
*	57.82	Closure of cystostomy
*	57.83	Repair of fistula involving bladder and intestine
	57.84	Repair of other fistula of bladder
*	57.92	Dilation of bladder neck
*	57.93	Control of (postoperative) hemorrhage of bladder
*	58.0	Urethrotomy
	58.21	Perineal urethroscopy
	58.22	Other urethroscopy
*	58.23	Biopsy of urethra
*	58.24	Biopsy of periurethral tissue
	58.3	Excision or destruction of urethral tissue or lesion
*	58.41	Suture of laceration of urethra
*	58.42	Closure of urethrostomy
*	58.43	Closure of other fistula of urethra
	58.5	Release of urethral stricture Cutting of urethral sphincter; Internal urethral meatotomy
*	58.6	Dilation of urethra Dilation of urethrovesical junction; Passage of sounds through urethra; Removal of calculus from urethra without incision
*	58.91	Incision of periurethral tissue
*	58.92	Excision of periurethral tissue
*	59.21	Biopsy of perirenal or perivesical tissue
	59.8	Ureteral catheterization
*	59.91	Excision of perirenal or perivesical tissue

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MALE GENITAL ORGANS (60-64)

	60.0	Incision of prostate
	60.11	Needle biopsy of prostate
	60.12	Other biopsy of prostate
*	60.13	Percutaneous biopsy of seminal vesicles (needle)
*	60.14	Other biopsy of seminal vesicles
*	60.15	Biopsy of periprostatic tissue
	60.2	Transurethral prostatectomy
*	60.61	Local excision of lesion of prostate
*	60.71	Percutaneous aspiration of seminal vesicle
*	60.81	Incision of periprostatic tissue Drainage of periprostatic abscess
*	60.91	Percutaneous aspiration of prostate
*	60.94	Control of postoperative hemorrhage of prostate
*	61.0	Incision and drainage of scrotum and tunica vaginalis
*	61.2	Excision of hydrocele (of tunica vaginalis)
*	61.41	Suture of laceration of scrotum and tunica vaginalis
*	61.42	Repair of scrotal fistula
*	61.92	Excision of lesion of tunica vaginalis other than hydrocele (hematocele)
*	62.0	Incision of testis
	62.12	Other biopsy of testis
*	62.2	Excision or destruction of testicular lesion
*	62.3	Unilateral orchiectomy
*	62.41	Removal of both testes at same operative episode
	62.42	Removal of remaining testis
	62.5	Orchiopexy
*	62.7	Insertion of testicular prosthesis
	63.1	Excision of varicocele and hydrocele of spermatic cord
	63.2	Excision of cyst of epididymis
	63.3	Excision of other lesion or tissue of spermatic cord and epididymis
	63.4	Epididymectomy
*	63.51	Suture of laceration of spermatic cord and epididymis
	63.6	Vasotomy (Vasostomy)
*	63.70	Male sterilization procedure, not otherwise specified
*	63.71	Ligation of vas deferens (Crushing/Division of)
*	63.72	Ligation of spermatic cord
	63.73	Vasectomy
*	63.81	Suture of laceration of vas deferens and epididymis
*	63.82	Reconstruction of surgically divided vas deferens
*	63.83	Epididymovasostomy
*	63.84	Removal of ligature from vas deferens
*	63.85	Removal of valve from vas deferens
*	63.92	Epididymotomy
*	63.94	Lysis of adhesions of spermatic cord
*	63.95	Insertion of valve in vas deferens
	64.0	Circumcision
*	64.91	Dorsal or lateral slit of prepuce
*	64.95	Insertion or replacement of internal prosthesis of penis
	64.96	Removal of internal prosthesis of penis

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FEMALE GENITAL ORGANS (65-71)

	65.0	Oophorotomy
*	65.11	Aspiration biopsy of ovary
*	65.12	Other biopsy of ovary
*	65.29	Other local excision or destruction of ovary Bisection, cauterization, partial excision of ovary
*	65.71	Simple suture of ovary
*	65.8	Lysis of adhesions of ovary and fallopian tube
*	65.91	Aspiration of ovary
*	66.0	Salpingotomy
*	66.11	Biopsy of fallopian tube
*	66.2	Bilateral endoscopic destruction or occlusion of fallopian tubes
	66.21	Bilateral endoscopic ligation and crushing of fallopian tubes
	66.22	Bilateral endoscopic ligation and division of fallopian tubes
	66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes
	66.31	Other bilateral ligation and crushing of fallopian tubes
	66.32	Other bilateral ligation and division of fallopian tubes (Pomeroy operation)
	66.39	Other bilateral destruction or occlusion of fallopian tubes
*	66.61	Excision or destruction of lesion of fallopian tube
*	66.71	Simple suture of fallopian tube
*	66.91	Aspiration of fallopian tube
*	66.92	Unilateral destruction or occlusion of fallopian tube
	67.2	Conization of cervix
	67.31	Marsupialization of cervical cyst
	67.4	Amputation of cervix Cervicectomy with synchronous colporrhaphy
	67.5	Repair of internal cervical os Cerclage of isthmus uteri; Shirodkar operation
	67.69	Other repair of cervix Repair of old obstetric laceration of cervix
*	68.14	Biopsy of uterine ligaments
*	68.21	Division of endometrial synechiae Lysis of intraluminal uterine adhesions
	68.22	Incision or excision of congenital septum of uterus
	68.29	Other excision or destruction of lesion of uterus
	69.01	Dilation and curettage for termination of pregnancy
	69.02	Dilation and curettage following delivery or abortion
	60.09	Other dilation and curettage (diagnostic)
*	69.19	Other excision or destruction of uterus and supporting structures
*	69.49	Other repair of uterus Repair of old obstetric laceration of uterus
	69.51	Aspiration curettage of uterus for termination of pregnancy
	69.52	Aspiration curettage following delivery or abortion
	69.59	Other aspiration curettage of uterus
	70.12	Culdotomy
	70.13	Lysis of intraluminal adhesions of vagina
	70.14	Other vaginotomy (Division of vaginal septum)
	70.22	Culdoscopy

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FEMALE GENITAL ORGANS continued

*	70.32	Excision or destruction of lesion of cul-de-sac
*	70.71	Suture of laceration of vagina
*	70.79	Other repair of vagina Repair of old obstetric laceration of vagina
	71.23	Marsupialization of Bartholin's gland (cyst)
	71.24	Excision or other destruction of Bartholin's gland (cyst)
*	71.61	Unilateral vulvectomy
*	71.71	Suture of laceration of vulva or perineum
*	71.79	Other repair of vulva and perineum Repair of old obstetric laceration of vulva or perineum

MUSCULOSKELETAL SYSTEM (76-84)

*	76.01	Sequestrectomy of facial bone
*	76.09	Other incision of facial bone
*	76.11	Biopsy of facial bone
*	76.2	Local excision or destruction of lesion of facial bone
*	76.67	Reduction genioplasty Reduction mentoplasty
*	76.68	Augmentation genioplasty Mentoplasty NOS or with graft or implant
*	76.72	Open reduction of malar and zygomatic fracture
*	76.74	Open reduction of maxillary fracture
*	76.76	Open reduction of mandibular fracture
*	76.79	Other open reduction of facial fracture Open reduction of orbit rim or wall
*	76.91	Bone graft to facial bone
*	76.92	Insertion of synthetic implant in facial bone
	76.94	Open reduction of temporomandibular dislocation

Sequestrectomy for codes:

*	77.00	Unspecified site
*	77.01	Scapula, clavicle, and thorax (ribs and sternum)
*	77.02	Humerus
*	77.03	Radius and ulna
*	77.04	Carpals and metacarpals
*	77.05	Femur
*	77.06	Patella
*	77.07	Tibia and fibula
*	77.08	Tarsals and metatarsals
*	77.09	Other

Other incision of bone without division (Reopening of osteotomy site) for codes:

*	77.10	Unspecified site
*	77.11	Scapula, clavicle, and thorax (ribs and sternum)
*	77.12	Humerus
*	77.13	Radius and ulna
*	77.14	Carpals and metacarpals
	77.15	Femur
*	77.16	Patella

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MUSCULOSKELETAL SYSTEM continued

	77.17	Tibia and fibula
*	77.18	Tarsals and metatarsals
*	77.19	Other
		Wedge osteotomy for codes:
*	77.20	Unspecified site
*	77.21	Scapula, clavicle, and thorax (ribs and sternum)
*	77.22	Humerus
*	77.23	Radius and ulna
*	77.24	Carpals and metacarpals
*	77.26	Patella
*	77.27	Tibia and fibula
*	77.28	Tarsals and metatarsals
*	77.29	Other
		Other division of bone (Osteoarthrotomy) for codes:
*	77.30	Unspecified site
*	77.31	Scapula, clavicle, and thorax (ribs and sternum)
*	77.32	Humerus
*	77.33	Radius and ulna
*	77.34	Carpals and metacarpals
*	77.36	Patella
*	77.37	Tibia and fibula
*	77.38	Tarsals and metatarsals
*	77.39	Other
		Biopsy of bone for codes:
*	77.40	Unspecified site
*	77.41	Scapula, clavicle, and thorax (ribs and sternum)
*	77.42	Humerus
*	77.43	Radius and ulna
*	77.44	Carpals and metacarpals
*	77.45	Femur
*	77.46	Patella
*	77.47	Tibia and fibula
*	77.48	Tarsals and metatarsals
*	77.49	Other
*	77.51	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal
*	77.52	Bunionectomy with soft tissue correction and arthrodesis
		Local excision of lesion or tissue of bone for codes:
*	77.60	Unspecified site
*	77.61	Scapula, clavicle, and thorax (ribs and sternum)
*	77.62	Humerus
*	77.63	Radius and ulna
*	77.64	Carpals and metacarpals
*	77.65	Femur
*	77.66	Patella
*	77.67	Tibia and fibula
	77.68	Tarsals and metatarsals
*	77.69	Other

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MUSCULOSKELETAL SYSTEM continued

	77.74	Excision of bone for graft - carpals and metacarpals
	77.79	Excision of bone for graft - other
		Other partial ostectomy for codes:
*	77.80	Unspecified site
*	77.81	Scapula, clavicle, and thorax (ribs and sternum)
*	77.82	Humerus
*	77.83	Radius and ulna
*	77.84	Carpals and metacarpals
*	77.85	Femur
*	77.86	Patella
*	77.87	Tibia and fibula
	77.88	Tarsals and metatarsals
*	77.89	Other
*	77.94	Total ostectomy - carpals and metacarpals
*	77.98	Total ostectomy - tarsals and metatarsals
*	77.99	Total ostectomy - other
	78.03	Bone graft - radius and ulna
	78.04	Bone graft - carpals and metacarpals
	78.09	Bone graft - other
*	78.14	Periosteal suture - carpals and metacarpals
*	78.18	Periosteal suture - tarsals and metatarsals
*	78.19	Periosteal suture - other
	78.22	Epiphyseal stapling - humerus
*	78.23	Epiphyseal stapling - radius and ulna
*	78.34	Other change in bone length - carpals and metacarpals
*	78.38	Other change in bone length - tarsals and metatarsals
		Internal fixation of bone without fracture reduction for codes:
*	78.50	Unspecified site
*	78.51	Scapula, clavicle, and thorax (ribs and sternum)
*	78.52	Humerus
*	78.53	Radius and ulna
*	78.54	Carpals and metacarpals
*	78.55	Femur
*	78.56	Patella
*	78.57	Tibia and fibula
*	78.58	Tarsals and metatarsals
*	78.59	Other
		Closed reduction of fracture with internal fixation for codes:
*	79.12	Radius and ulna
*	79.13	Carpals and metacarpals
*	79.14	Phalanges of hand
*	79.17	Tarsals and metatarsals
*	79.18	Phalanges of foot
		Open reduction of fracture without internal fixation for codes:
*	79.23	Carpals and metacarpals

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MUSCULOSKELETAL SYSTEM continued

	79.24	Phalanges of hand
*	79.27	Tarsals and metatarsals
*	79.28	Phalanges of foot
		Open reduction of fracture with internal fixation for codes:
*	79.33	Carpals and metacarpals
*	79.34	Phalanges of hand
*	79.37	Tarsals and metatarsals
*	79.38	Phalanges of foot
		Closed reduction of separated epiphysis for codes:
*	79.41	Humerus
*	79.42	Radius and ulna
*	79.45	Femur
*	79.46	Tibia and fibula
		Other arthrotomy (arthrostomy) for codes:
	80.10	Unspecified site
	80.11	Shoulder
	80.12	Elbow
	80.13	Wrist
	80.14	Hand and finger
	80.16	Knee
	80.17	Ankle
	80.18	Foot and toe
	80.19	Other specified sites
		Arthroscopy for codes:
	80.20	Unspecified site
	80.21	Shoulder
	80.22	Elbow
	80.23	Wrist
	80.24	Hand and finger
	80.25	Hip
	80.26	Knee
	80.27	Ankle
	80.28	Foot and toe
	80.29	Other specified sites
		Division of joint capsule, ligament, or cartilage for codes:
	80.40	Unspecified site
	80.41	Shoulder
	80.42	Elbow
	80.43	Wrist
	80.44	Hand and finger
	80.46	Knee
	80.47	Ankle
	80.48	Foot and toe
	80.49	Other specified sites
	80.6	Excision of semilunar cartilage of knee Excision of meniscus of knee

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MUSCULOSKELETAL SYSTEM continued

		Synovectomy (Complete or partial resection of synovial membrane) for codes:
*	80.70	Unspecified site
*	80.71	Shoulder
*	80.72	Elbow
*	80.73	Wrist
*	80.74	Hand and finger
*	80.76	Knee
*	80.77	Ankle
*	80.78	Foot and toe
*	80.79	Other specified sites
		Other local excision or destruction of lesion of joint for codes:
	80.80	Unspecified site
	80.81	Shoulder
	80.82	Elbow
	80.83	Wrist
	80.84	Hand and finger
	80.86	Knee
	80.87	Ankle
	80.88	Foot and toe
*	80.89	Other specified sites
		Other excision of joint for codes:
*	80.90	Unspecified site
	80.91	Shoulder
	80.92	Elbow
*	80.93	Wrist
*	80.94	Hand and finger
*	80.96	Knee
*	80.97	Ankle
*	80.98	Foot and toe
*	80.99	Other specified sites
	81.16	Metatarsophalangeal fusion
	81.18	Other fusion of toe
*	81.26	Metacarpocarpal fusion
*	81.27	Metacarpophalangeal fusion
*	81.28	Interphalangeal fusion
*	81.31	Arthroplasty of foot and toe with synthetic prosthesis
	81.39	Other arthroplasty of foot and toe
*	81.45	Other repair of the cruciate ligaments
*	81.46	Other repair of the collateral ligaments
*	81.91	Arthrocentesis (Joint aspiration)
*	81.93	Suture of capsule or ligament of upper extremity
*	81.94	Suture of capsule or ligament of ankle and foot
*	81.95	Suture of capsule or ligament of other lower extremity
	82.01	Exploration of tendon sheath of hand
*	82.02	Myotomy of hand
*	82.03	Bursotomy of hand
	82.04	Incision and drainage of palmar or thenar space
	82.11	Tenotomy of hand

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MUSCULOSKELETAL SYSTEM continued

*	82.12	Fasciotomy of hand
	82.21	Excision of lesion of tendon sheath of hand Ganglionectomy of tendon sheath (wrist)
*	82.22	Excision of lesion of muscle of hand
*	82.31	Bursectomy of hand
*	82.32	Excision of tendon of hand for graft
*	82.33	Other tenonectomy of hand (Tenosynovectomy)
*	82.34	Excision of muscle or fascia of hand for graft
	82.35	Other fasciectomy of hand Release of Dupuytren's contracture
*	82.36	Other myectomy of hand
*	82.41	Suture of tendon sheath of hand
*	82.42	Delayed suture of flexor tendon of hand
*	82.43	Delayed suture of other tendon of hand
*	82.44	Other suture of flexor tendon of hand
*	82.45	Other suture of other tendon of hand
*	82.46	Suture of muscle or fascia of hand
*	82.51	Advancement of tendon of hand
*	82.52	Recession of tendon of hand
*	82.53	Reattachment of tendon of hand
*	82.54	Reattachment of muscle of hand
*	82.55	Other change in hand muscle or tendon length
*	82.56	Other hand tendon transfer or transplantation
*	82.57	Other hand tendon transposition
*	82.58	Other hand muscle transfer or transplantation
*	82.59	Other hand muscle transposition
*	82.84	Repair of mallet finger
*	82.85	Other tenodesis of hand
	82.86	Other tenoplasty of hand
*	82.89	Other plastic operations on hand
	82.91	Lysis of adhesions of hand
*	83.01	Exploration of tendon sheath
	83.02	Myotomy
*	83.03	Bursotomy
*	83.11	Achillotenotomy
	83.13	Other tenotomy Aponeurotomy; Division of tendon
*	83.14	Fasciotomy
*	83.19	Other division of soft tissue Muscle release; Myotomy with division; Scalenotomy
*	83.21	Biopsy of soft tissue
*	83.31	Excision of lesion of tendon sheath Excision of ganglion of tendon sheath, except of hand
	83.32	Excision of lesion of muscle
	83.39	Excision of lesion of other soft tissue (Baker's cyst)
	83.41	Excision of tendon for graft
	83.42	Other tenonectomy Excision of aponeurosis, tendon sheath; Tenosynovectomy
*	83.44	Other fasciectomy
*	83.5	Bursectomy
*	83.61	Suture of tendon sheath
*	83.62	Delayed suture of tendon

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MUSCULOSKELETAL SYSTEM continued

*	83.64	Other suture of tendon Achillorrhaphy; Aponeurorrhaphy
	83.65	Other suture of muscle or fascia Repair of diastasis recti
*	83.73	Reattachment of tendon
*	83.74	Reattachment of muscle
*	83.75	Tendon transfer or transplantation
*	83.76	Other tendon transposition
*	83.87	Other plastic operations on muscle
	83.88	Other plastic operations on tendon
*	83.91	Lysis of adhesions of muscle, tendon, fascia, and bursa
	84.01	Amputation and disarticulation of finger
	84.02	Amputation and disarticulation of thumb
	84.11	Amputation of toe
*	84.3	Revision of amputation stump (Trimming)

INTEGUMENTARY SYSTEM (85-86)

	85.0	Mastotomy
	85.12	Other biopsy of breast
	85.20	Excision or destruction of breast tissue, not otherwise specified
	85.21	Local excision of lesion of breast
	85.22	Resection of quadrant of breast
	85.23	Subtotal mastectomy
	85.24	Excision of ectopic breast tissue
	85.25	Excision of nipple
*	85.31	Unilateral reduction mammoplasty
*	85.32	Bilateral reduction mammoplasty
*	85.33	Unilateral subcutaneous mammectomy with synchronous implant
*	85.34	Other unilateral subcutaneous mammectomy
*	85.35	Bilateral subcutaneous mammectomy with synchronous implant
*	85.36	Other bilateral subcutaneous mammectomy
*	85.50	Augmentation mammoplasty, not otherwise specified
*	85.53	Unilateral breast implant
*	85.54	Bilateral breast implant
*	85.6	Mastopexy
*	85.82	Split-thickness graft to breast
	85.83	Full-thickness graft to breast
*	85.86	Transposition of nipple
*	85.87	Other repair or reconstruction of nipple
*	85.89	Other mammoplasty
*	85.93	Revision of implant of breast
	85.94	Removal of implant of breast
	86.21	Excision of pilonidal cyst or sinus Marsupialization of cyst
	86.4	Radical excision of skin lesion Wide excision of skin lesion involving underlying or adjacent structure
	86.60	Free skin graft, not otherwise specified

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INTEGUMENTARY SYSTEM continued

	86.61	Full-thickness skin graft to hand
*	86.62	Other skin graft to hand
	86.63	Full-thickness skin graft to other sites
*	86.65	Heterograft to skin
*	86.66	Homograft to skin
	86.69	Other skin graft to other sites
	86.70	Pedicle or flap graft, not otherwise specified
	86.71	Cutting and preparation of pedicle grafts or flaps
	86.72	Advancement of pedicle graft
	86.73	Attachment of pedicle or flap graft to hand
	86.74	Attachment of pedicle or flap graft to other sites
	86.75	Revision of pedicle or flap graft
*	86.82	Facial rhytidectomy
*	86.83	Size reduction plastic operation
	86.84	Relaxation of scar or web contracture of skin Z-plasty of skin
*	86.85	Correction of syndactyly

MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC PROCEDURES (87-99)

	87.21	Contrast myelogram
*	87.66	Contrast pancreatogram
*	87.74	Retrograde pyelogram
*	87.75	Percutaneous pyelogram
*	87.76	Retrograde cystourethrogram
	87.91	Constrast seminal vesiculogram
*	87.93	Contrast epididymogram
*	87.94	Contrast vasogram
	88.40	Arteriography using contrast material, unspecified site
	88.41	Arteriography of cerebral arteries
	88.42	Aortography
	88.43	Arteriography of pulmonary arteries
	88.44	Arteriography of other intrathoracic vessels
	88.45	Arteriography of renal arteries
	88.46	Arteriography of placenta
	88.47	Arteriography of other intra-abdominal arteries
	88.48	Arteriography of femoral and other lower extremity arteries
	88.49	Arteriography of other specified sites
	88.50	Angiocardiography, not otherwise specified
	88.51	Angiocardiography of venae cavae
	88.52	Angiocardiography of right heart structures
	88.53	Angiocardiography of left heart structures
	88.54	Combined right and left heart angiocardiography
	88.55	Coronary arteriography using a single catheter
	88.56	Coronary arteriography using two catheters
	88.57	Other and unspecified coronary arteriography
	94.27	Other electroshock therapy Electroconvulsive therapy (ECT); EST
	95.04	Eye examination under anesthesia (general)

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MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC PROCEDURES continued

	98.02	Removal of intraluminal foreign body from esophagus without incision
*	98.03	Removal of intraluminal foreign body from stomach and small intestine without incision
	98.15	Removal of intraluminal foreign body from trachea and bronchus without incision
*	99.62	Other electric countershock of heart (cardioversion)

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APPENDIX C

DEPARTMENT OF THE ARMY

RECOMMENDED LIST OF

AMBULATORY SURGERY PROCEDURES

SUGGESTED PROCEDURES FOR SAME DAY SURGERY

ICD-9-CM CODE	TITLE
1. OPERATIONS ON THE NERVOUS SYSTEM (01-05)	
04.2	Destruction of Cranial and Peripheral Nerves
04.3	Suture of Cranial and Peripheral Nerves
04.6	Transposition of Cranial and Peripheral Nerves
04.79	Other Neuroplasty
2. OPERATIONS ON THE ENDOCRINE SYSTEM (06-07)	
06.7	Excision of Thyroglossal Duct or Tract
3. OPERATIONS ON THE EYE (08-16)	
08.09	Other Incision of Eyelid
08.20	Removal of Lesion of Eyelid, Not Otherwise Specified
08.3	Repair of Blepharoptosis and Lid Retraction
08.49	Other Repair of Entropion or Ectropion
08.52	Blepharorrhaphy
08.59	Other Adjustment of Lid Position
08.63	Reconstruction of Eyelid with Hair Follicle Graft (Eyebrows and Eyelids)
08.70	Reconstruction of Eyelid, NOS (Blepharoplasty)
08.71	Reconstruction of Eyelid, Involving Lid Margin, Partial Thickness
08.89	Other Eyelid Repair
08.99	Other Operations on Eyelids
09.0	Incision of Lacrimal Gland
09.20	Excision of Larcimal Gland, Not Otherwise Specified
09.3	Other Operations on Lacrimal Gland
09.49	Other Manipulation of Lacrimal Passage
09.51	Incision of Lacrimal Punctum (Splitting of Lacrimal Papillae)
09.53	Incision of Lacrimal Sac
09.59	Other Incision of Lacrimal Passages
09.6	Excision of Lacrimal Sac and Passage
09.72	Other Repair of Punctum
09.73	Repair of Canaliculus
09.99	Other Operations on Lacrimal System

ICD-9-CM CODE	TITLE
10.0	Removal of Embedded Foreign Body From Conjunctiva by Incision
10.1	Other Incision of Conjunctiva
10.31	Excision of Lesion or Tissue of Conjunctiva
10.33	Curettage-Other Destructive Procedures on Conjunctiva
10.44	Mucosal Graft (Other Graft to Conjunctiva)
10.49	Other Conjunctivoplasty
10.5	Lysis of Adhesions of Conjunctiva and Eyelid
10.6	Repair of Laceration of Conjunctiva
10.99	Other Operations on Conjunctiva
11.0	Magnetic Removal of Embedded Foreign Body from Cornea
11.1	Incision of Cornea
11.31	Transportation of Pterygium
11.32	Excision of Ptergyium with Corneal Graft
11.39	Other Excision of Pterygium
11.49	Other Removal or Destruction of Corneal Lesion
11.51	Suture of Corneal Laceration
11.60	Corneal Transplant, Not Otherwise Specified
11.61	Corneal Transplant, Lamellar Keratoplasty with Autograft
11.62	Other Lamellar Keratoplasty
11.63	Penetrating Keratoplasty with Autograft
11.64	Other Penetrating Keratoplasty, Perforating Keratoplasty (with Homograft)
11.69	Other Corneal Transplant
11.79	Other Reconstructive Surgery on Cornea
11.91	Tattooing of Cornea
11.92	Removal of Artificial Implant from Cornea
11.99	Other Operations on Cornea
12.01	Removal of Intraocular Foreign Body from Anterior Segment of Eye with Use of Magnet
12.11	Transfixion of Iris, Iridotomy
12.12	Other Iridotomy, Sphincterotomy of Iris
12.14	Other Iridectomy, Optical Iridectomy
12.31	Lysis of Goniosynechiae
12.32	Lysis of Other Anterior Synechiae
12.39	Other Iridoplasty

ICD-9-CM CODE	TITLE
12.40	Removal of Lesion of Anterior Segment of Eye
12.41	Destruction of Lesion of Iris, Nonexcisional
12.42	Iridocystectomy (Peripheral) Excision of Lesion of Iris
12.43	Destruction of Lesion of Ciliary Body Nonexcisional
12.44	Excision of Lesion of Ciliary Body
12.47	Diminution of Ciliary Body, NOS
12.51	Goniopuncture (Goniopuncture without Goniotomy)
12.54	Trabeculotomy (ab externo)
12.55	Cyclotomy, Cycloliadlysis, Ciliarotomy
12.59	Other Facilitation of Intraocular Circulation
12.63	Iridencleisis and Iridotasis
12.65	Sclerectomy
12.69	Iridosclerotomy, Other Fistulizing Procedure
12.79	Other Glaucoma Procedures
12.81	Suture of Sclera
12.84	Excision or Destruction of Lesion of Sclera
12.89	Other Operations on Sclera
12.99	Other Operations on Anterior Chamber
13.01	Removal of Foreign Body from Lens with Use of Magnet
13.02	Removal of Foreign Body from Lens without Use of Magnet
13.19	Other Intracapsular Extraction of Lens
13.41	Phacoemulsification and Aspiration of Cataract
13.51	Extracapsular Extraction of Lens by Temporal Inferior Route (Capsulectomy)
13.59	Other Extracapsular Extraction of Lens
13.65	Excision of Secondary Membrane (After Cataract) (Capsulectomy)
13.69	Other Cataract Extraction
13.70	Insertion of Pseudophakos, Not Otherwise Specified
13.8	Removal of Implanted Lens
13.9	Other Operations on Lens
14.59	Other Repair of Retinal Detachment
14.75	Injection of Vitreous Substitute (See "Excludes")
14.79	Other Operations on Vitreous
15.11	Recession of One Extrocular Muscle
15.13	Resection of One Extraocular Muscle

ICD-9-CM CODE	TITLE
15.2	Other Operations on One Extraocular Muscle
15.22	Shortening Procedures on One Extraocular Muscle
15.3	Operations on Two More Extraocular Muscles Involving Temporary Detachment from Globe, One or Both Eyes
15.4	Other Operations on Two or More Extraocular Muscles, One or Both Eyes
15.5	Transposition of Extraocular Muscle
15.7	Repair of Injury of Extraocular Muscle
15.9	Other Operations on Extraocular Muscles and Tendons
16.1	Removal of Penetrating Foreign Body from Eye
4. OPERATIONS ON THE EAR (18-20)	
18.29	Excision or Destruction of Other Lesion of External Ear
18.5	Surgical Correction of Prominent Ear
18.6	Reconstruction of External Auditory Canal
18.71	Reconstructuon of Auricle of Ear
18.79	Other Plastic Repair of External Ear
18.9	Other Operations on External Ear
19.3	Other Operations on Ossicular Chain
19.4	Myringoplasty
20.09	Other Myringotomy
20.01	Myringotomy with Insertion of Tube (Insertion of Tympanotomy Tube)
20.1	Removal of Tympanostomy Tube
20.51	Excision of Lesion of Middle Ear (Excision of Cholesteatoma)
20.59	Other Excision of Middle Ear (Removal of Outer Attic Wall)
5. OPERATIONS ON THE NOSE, MOUTH, AND PHARYNX (21-29)	
21.30	Excision or Destruction of Lesion of Nose
21.31	Polypectomy
21.61	Turbinectomy by Diathermy or Cryosurgery
21.62	Fracture of the Turbinates
21.69	Other Turbinectomy
21.71	Closed Reduction of Nasal Fracture
21.8	Repair and Plastic Operations on the Nose (Excludes 2183, Total Reconstruction)
21.99	Other Operations on Nose

ICD-9-CM CODE	TITLE
22.2	Intranasal Antrotomy
22.39	Other External Maxillary Antrotomy
22.60	Sinusectomy, Not Otherwise Specified
22.71	Closure of Nasal Sinus Fistula (Repair of Oro-Antral Fistula)
22.79	Other Repair of Nasal Sinus
23.01	Extraction of Deciduous Tooth
23.09	Extraction of Other Tooth
23.10	Other Surgical Extraction of Tooth
23.11	Removal of Residual Root
23.2	Restoration of Tooth by Filling
23.49	Other Dental Restoration
24.5	Alveoloplasty
24.91	Vestibuloplasty
25.01	Needle Biopsy of Tongue
25.02	Other Biopsy of Tongue
25.09	Other Diagnostic Procedures of Tongue
25.91	Lingual Frenotomy
26.0	Incision of Salivary Gland or Duct
26.99	Other Operations on Salivary Gland or Duct
27.24	Biopsy of Mouth, Unspecified Structure
27.56	Other Skin Graft to Lip and Mouth
27.59	Other Plastic Repair of Mouth
28.2	Tonsillectomy without Adenoidectomy
28.3	Tonsillectomy with Adenoidectomy
28.6	Adenoidectomy without Tonsillectomy
29.2	Excision of Branchial Cleft Cyst or Vestige (Only If Non-Infected)
6. OPERATIONS ON THE RESPIRATORY SYSTEM (30-34)	
30.09	Other Excision or Destruction of Lesion or Tissue of Larynx
31.0	Injection of Larynx
31.42	Laryngoscopy and other Tracheoscopy
33.24	Other Bronchoscopy
33.26	Percutaneous (Needle) Biopsy of Lung

ICD-9-CM CODE	TITLE
34.24	Pleural Biopsy
34.91	Thoracentesis
7. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (35-39)	
37.85	Replacement of Cardiac Pacemaker Pulse Generator
38.50	Ligation and Stripping of Varicose Veins, Unspecified Site
38.59	Stripping Varicose Veins (Lower Limb)
38.92	Umbilical Vein Catheterization
38.93	Other Venous Catheterization
39.30	Suture of Unspecified Blood Vessel
8. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEM (40-41)	
40.11	Biopsy of Lymphatic Structure
40.29	Simple Excision of other Lymphatic Structure
41.31	Biopsy of Bone Marrow
9. OPERATIONS ON THE DIGESTIVE SYSTEM (42-54)	
42.24	Biopsy of Esophagus
44.12	Gastroscopy Through Artificial Stoma
44.13	Other Gastroscopy
45.22	Endoscopy of Large Intestine through Stoma (Artificial)
45.24	Other Endoscopy of Large Intestine
48.25	Other Biopsy of Rectum
48.32	Other Electrocoagulation of Rectal Lesion or Tissue
48.35	Local Excision of Rectal Lesion or Tissue
48.81	Incision of Perirectal Tissue
49.10	Incision or Excision of Anal Fistula
49.11	Anal Fistulotomy
49.12	Anal Fistulectomy
49.23	Biopsy of Anus
49.3	Local Excision or Destruction of other Lesion or Tissue of Anus
49.46	Excision of Hemorrhoids (Banding only)
49.51	Left Lateral Anal Sphincterotomy

ICD-9-CM CODE	TITLE
49.52	Posterior Anal Sphincterotomy
49.59	Other Anal Sphincterotomy
50.11	Percutaneous (Needle) Biopsy of Liver
53.00	Unilateral Repair of Inguinal Hernia, Not Otherwise Specified
53.10	Bilateral Repair of Inguinal Hernia, NOS
53.20	Unilateral Repair Femoral Hernia
53.30	Bilateral Repair of Femoral Hernia
53.4	Repair of Umbilical Hernia
53.41	Repair of Umbilical Hernia With Prosthesis
53.49	Other Umbilical Herniorrhaphy
53.59	Repair of other Hernia or Anterior Abdominal Wall
54.21	Laparoscopy
54.22	Biopsy of Abdominal Wall or Umbilicus
54.97	Injection of Locally-Acting Therapeutic Substance
54.98	Peritoneal Dialysis
54.99	Other Operations of Abdominal Region
10. OPERATIONS ON THE URINARY SYSTEM (55-59)	
55.01	Nephrotomy
55.11	Pyelotomy
55.22	Pyeloscopy
56.1	Ureteral Meatotomy
56.31	Ureteroscopy
56.99	Other Operations on Ureter
57.32	Other Cystoscopy
57.33	Transurethral Biopsy of Bladder
57.34	Other Biopsy of Bladder
57.49	Other Transurethral Excision or Destruction of Lesion or Tissue of Bladder
58.1	Urethral Meatotomy
58.23	Biopsy of Urethra
58.45	Repair of Hypospadias and Epispadias
58.5	Release of Urethral Stricture
58.6	Dilation of Urethra

ICD-9-CM CODE	TITLE
11. OPERATIONS ON THE MALE GENITAL SYSTEM (60-64)	
60.11	Needle Biopsy of Prostate
60.12	Other Biopsy of Prostate
61.2	Excision of Hydrocele (of Tunica Vaginalis)
62.11	Percutaneous Biopsy of Testis
62.12	Other Biopsy of Testis
62.3	Unilateral Orchiectomy
62.30	Unilateral Removal of Ovotestis
62.41	Removal of Both Testes at Same Operative Episode
62.42	Removal of Remaining Testis
62.5	Orchiopexy
63.30	Excision of Other Lesion or Tissue of Spermatic Cord and Epididymis (for Excision of Lesion)
63.1	Excision of Varicocele and Hydrocele of Spermatic Cord
63.59	Repair of Hydrocele of Cord
63.73	Vasectomy
64.0	Circumcision
64.11	Biopsy of Penis
64.41	Suture of Laceration of Penis
64.42	Release of Chordee
64.44	Reconstruction
64.49	Other Repair of Penis
64.93	Division of Penile Adhesions
64.98	Irrigation, Corpus Cavernosum
64.99	Other Operations on Male Genital Organs
12. OPERATIONS ON THE FEMALE GENITAL SYSTEM (65-71)	
66.2	Bilateral Endoscopic Destruction or Occulsion of Fallopian Tubes
69.01	D&C for Termination of Pregnancy
69.02	D&C Following Delivery or Abortion
69.09	Other D&C (Diagnostic)
69.51	Aspiration Curettage of Uterus for Termination of Pregnancy

ICD-9-CM CODE	TITLE
69.59	Other Aspiration Curettage of Uterus
69.97	Removal of Other Penetrating Foreign Body from Cervix
70.14	Other Vaginotomy (Removal of Foreign Body by Incision)
70.31	Excision of Hymen
70.33	Excision or Destruction of Lesion of Vagina
70.91	Other Operations on Vagina
71.11	Biopsy of Vulva
71.3	Other Local Excision or Destruction of Vulva and Perineum
71.71	Perineorrhapy
71.72	Closure of Perineal Fistula
71.79	Other Repair of Vulva and Perineum

13. OBSTETRICAL PROCEDURES (72-75)

14. OPERATIONS ON THE MUSCULO-SKELETAL SYSTEM (76-84)

76.01	Removal of sequestrum
76.09	Other Incision of Facial Bone
76.61	Closed Osteoplasty of Mandibular Ramus (Ramisection, Condylotomy)
76.62	Open Osteoplasty of Mandibular Ramus (Ramisection, Condylotomy)
76.67	Reduction Genioplasty
76.68	Augmentation Genioplasty
76.69	Other Facial Bone Repair
76.71	Closed Reduction of Malar and Zygomatic Fracture
76.73	Closed Reduction of Maxillary Fracture
76.75	Closed Reduction of Mandibular Fracture
76.78	Other Closed Reduction of Facial Fracture
77.20	Wedge Osteotomy Unspecified Site
77.30	Other Division of Bone, Osteotomy
77.54	Excision of Bunionette
77.59	Other Bunionectomy
77.60	Local Excision of Lesion or Tissue of Bone, Unspecified Site
77.68	Excision of Metatarsal Head or Phalanx
77.80	Other Partial Ostectomy, Unspecified Site (Hand and Foot only)
77.90	Total Ostectomy, Unspecified Site (Hand and Foot only)

ICD-9-CM CODE	TITLE
78.50	Internal Fixation of Bone Without Fracture Reduction
78.60	Removal of Internal Fixation Device, Unspecified Site (Superficial Only)
79.02	Closed Reduction of Fracture of Radius and Ulna Without Internal Fixation
79.03	Closed reduction of Fracture (Carpals and Metacarpals) Without Internal Fixation
79.04	Closed Reduction of Fracture Without Internal Fixation (Phalanges of Hand)
79.06	Closed Reduction of Fracture of Tibia and Fibula Without Internal Fixation
79.07	Closed Reduction of Fracture without Internal Fixation (Tarsals and Metatarsals)
79.12	Closed Reduction of Fracture with Internal Fixation Radius and Ulna
79.13	Closed Reduction of Fracture with Internal Fixation Carpals and Metacarpals
79.14	Closed Reduction of Fracture with Internal Fixation Phalanges of Hand
79.17	Closed Reduction of Fracture with Internal Fixation Tarsals and Metatarsals
79.18	Closed Reduction of Fracture with Internal Fixation Phalanges of Foot
79.2	Open Reduction of Fracture without Internal Fixation, (Hand and Foot only)
79.3	Open Reduction of Fracture with Internal Fixation, (Hand and Foot only)
79.7	Closed Reduction of Dislocation of Unspecified Site (Wrist, Hand, Ankle and Foot only)
80.10	Other Arthrotomy, Unspecified Site (Hand and Foot only)
80.20	Arthroscopy, Unspecified Site
80.30	Biopsy of Joint Structure, Unspecified Site
80.40	Division of Joint Capsule, Ligament, or Cartilage, (Arthroscopic, Hand and Foot only)
80.6	Excision of Semilunar Cartilage of Knee
80.70	Syndvectomy, Unspecified Site
80.80	Other Local Excision or Destruction of Lesion of Joint, (Arthroscopic only)
80.90	Other Excision of Joint, Unspecified Site (Arthroscopic only)
81.11	Ankle Fusion
81.20	Arthrodesis of Unspecified Joint (Hand and Foot Only)
81.79	Other Repair of Hand and Finger
81.96	Other Repair of Joint
82.0	Incision of Muscle, Tendon, Fascia, and Bursa of Hand
82.1	Division of Muscle, Tendon, Fascia on Hand
82.2	Excision of Lesion of Muscle, Tendon, and Fascia of Hand
82.3	Other Excision of Soft Tissue of Hand
82.4	Suture of Muscle, Tendon, and Fascia of Hand
82.7	Plastic Operation on Hand with Graft or Implant
82.8	Other Plastic Operations on Hand
82.84	Repair of Mallet Finger

ICD-9-CM CODE	TITLE
82.85	Other Tenodesis of Hand
82.86	Other Tenoplasty of Hand
82.89	Other Plastic Operations on Hand
82.89	Other Plastic Operations on Hand
82.9	Other Operations on Muscle, Tendon, and Fascia of Hand
83.0	Incision of Muscle, Tendon, Fascia, and Bursa
83.13	Other Tenotomy (Transection of Tendon)
83.14	Fasciotomy
83.19	Other Division of Soft Tissue
83.2	Diagnostic Procedures on Muscle, Tendon, Fascia, and Bursa, Including Hand
83.3	Excision of Lesion of Muscle, Tendon, Fascia, and Bursa
83.4	Other Excision of Muscle, Tendon, and Fascia, (Except Scalenectomy)
83.6	Suture of Muscle, Tendon, and Fascia
83.61	Suture of Tendon Sheath
83.62	Delayed Suture of Tendon
83.64	Other Suture of Tendon
83.8	Other Plastic Operations on Muscle, Tendon, and Fascia
83.9	Other Operations on Muscle, Tendon, Fascia, and Bursa
84.01	Amputation and Disarticulation of Finger
84.11	Amputation of Toe
84.3	Revision of Amputation Stump
15. OPERATIONS ON THE INTEGUMENTARY SYSTEM (85-86)	
85.0	Mastotomy
85.11	Percutaneous (Needle) Biopsy of Breast
85.12	Other Biopsy of Breast
85.20	Excision or Destruction of Breast Tissue
85.21	Local Excision of Lesion of Breast
85.24	Excision of Ectopic Breast Tissue (Excision of Supernumery Breast)
85.50	Augmentation Mammoplasty, Not Otherwise Specified
85.51	Unilateral Injection Into Breast for Augmentation
85.52	Injection into Breast for Augmentation (Bilateral)
85.53	Unilateral Breast Implant

ICD-9-CM CODE	TITLE
85.54	Bilateral Breast Implant
85.60	Mastopexy
85.81	Suture of Laceration of Breast
85.82	Split-Thickness Graft to Breast
85.83	Full-Thickness graft to breast
85.89	Other Mammoplasty
86.04	Other Incision with Drainage of Skin and Subcutaneous tissue (Drainage)
86.05	Incision with Removal of Foreign Body from Skin and Subcutaneous Tissue (Removal of Foreign Body)
86.09	Other Incision of Skin and Subacutaneous Tissue
86.11	Biopsy of Skin and Subcutaneous Tissue
86.21	Excision of Pilonidal Cyst or Sinus
86.22	Debridement of Wound, Infection, or Burn
86.23	Removal of Nail, Nailbed, or Nail Fold
86.24	Chemosurgery of Skin
86.25	Dermabrasion
86.3	Other Local Excision or Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue
86.59	Suture of Skin and Subcutaneous Tissue of Other Sites
86.60	Free Skin Graft, Not Otherwise Specified
86.62	Other Skin Graft to Hand
86.75	Revision of Pedicle or Flap Graft
86.81	Repair for Facial Weakness
86.82	Facial Rhytidectomy
86.84	Relaxation of Scar or Web Contracture of Skin
86.85	Correction of Syndactyly
86.89	Other Repair and Reconstruction of Skin and Subcutaneous Tissue
86.99	Other Operations on Skin and Subcutaneous Tissue
16. MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC PROCEDURES (87-99)	
87.54	Other Cholangiogram
87.52	Intravenous Cholangiogram
87.59	Cholecystogram

ICD-9-CM CODE	TITLE
88.45	Arteriography of Renal Arteries
89.29	Calibration of Urethra
93.26	Manual Rupture of Joint Adhesions
93.53	Application of other Cast
93.54	Application of Splint
96.03	Insertion of Esophageal Obturator Airway
96.16	Other Vaginal Dilation
96.23	Dialation of Anal Sphincter
96.24	Dilation and Manipulation of Enterostomy Stoma
97.71	Removal of Intrauterine Contraceptive Device
97.88	Removal of External Immobilization Device
98.0	Removal of Intraluminal Foreign Body from Digestive System without Incision
98.1	Removal of Intraluminal Foreign Body from Other Sites without Incision
98.2	Removal of other Foreign Body without Incision
98.06	Tamponade, Insertion of Sengstaken Tube
98.16	Removal of Intraluminal Foreign Body from Uterus without Incision
98.17	Removal of Intraluminal Foreign Body from Vagina without Incision
99.62	Other Electric Countershock of Heart

APPENDIX D

LIST OF POTENTIAL AMBULATORY SURGERY PROCEDURES

FOR KELLER ARMY COMMUNITY HOSPITAL

KELLER ARMY COMMUNITY HOSPITAL

RECOMMENDED PROCEDURES FOR AMBULATORY SURGERY

1. OPERATIONS ON THE EYE

ICD-9-CM CODE	PROCEDURE
08.20	Removal of Lesion of Eyelid, Not Otherwise Specified
08.21	Excision of Chalazion
08.22	Excision of Minor Lesion of Eyelid
08.89	Other Eyelid Repair
08.99	Other Operations on Eyelids
10.44	Mucosal Graft (Other Graft of Conjunctiva)
11.49	Other Removal or Destruction of Corneal Lesion
11.99	Other Operations on Cornea
12.22	Biopsy of Iris
13.59	Extracapsular Extraction of Lens
15.11	Recession of One Extraocular Muscle
15.30	Operations on Two More Extraovular Muscles Involving Temporary Detachment from Globe, One or Both Eyes

2. OPERATIONS ON THE EAR, NOSE, MOUTH AND PHARYNX

ICD-9-CM CODE	PROCEDURE
19.40	Myringoplasty
20.01	Myringotomy with Insertion of Tube (Inseriton of Tympanotomy Tube)
20.10	Removal of Typanostomy Tube
21.31	Polypectomy
21.71	Closure of Nasal Sinus Fistula
27.24	Biopsy of Mouth, Unspecified Structure
28.20	Tonsillectomy without Adenoidectomy
28.30	Tonsillectomy with Adenoidectomy
28.60	Adenoidectomy with Tonsillectomy

3. OPERATIONS OF THE RESPIRATORY, HEMIC AND LYMPHATIC SYSTEM

ICD-9-CM CODE	PROCEDURE
31.42	Laryngoscopy and Other Tracheoscopy
33.26	Percutaneous (Needle) Biopsy of Lung
34.91	Thoracentesis
41.31	Biopsy of Bone Marrow

4. OPERATIONS ON THE DIGESTIVE SYSTEM

ICD-9-CM CODE	PROCEDURE
42.24	Biopsy of Esophagus
45.22	Endoscopy of Large Intestine through Stoma (Artificial)
45.23	Colonscopy

ICD-9-CM CODE	PROCEDURE
45.24	Other Endoscopy of Large Intestine
49.11	Anal Fistulotomy
49.12	Anal Fistulectomy
49.46	Excision of Hemorrhoids
53.59	Repair of other Hernia or Anterior Abdominal Wall
54.21	Laparoscopy

5. OPERATIONS ON THE URINARY SYSTEM

ICD-9-CM CODE	PROCEDURE
55.01	Nephrotomy
57.32	Cystoscopy
57.33	Transurethral Biopsy of Bladder
57.49	Other Transurethral Excision or Destruction of Lesion or Tissue of Bladder
58.50	Release of Urethral Stricture
58.60	Dilation of Urethra

6. OPERATIONS ON THE MALE GENITAL SYSTEM

ICD-9-CM CODE	PROCEDURE
60.11	Needle Biopsy of Prostate
60.12	Other Biopsy of Prostate
60.19	Other Diagnostic Procedure on Seminal Vesicles
62.11	Percutaneous Biopsy of Testis
62.12	Other Biopsy of Testis
63.10	Excision of Varicocele and Hydrocele of Spermatic Cord
63.73	Vasectomy
64.00	Circumcision

7. OPERATIONS ON THE FEMALE GENITAL SYSTEM

ICD-9-CM CODE	PROCEDURE
67.39	Other Excision or Destruction of Lesion of Tissue or Tissue of Cervix
68.13	Uterine Biopsy
68.29	Other Excision or Destruction of Lesion of Uterus
69.01	D&C for Termination of Pregnancy
69.02	D&C Following Delivery or Abortion
69.09	Other D&C (Diagnostic)
69.52	Dilation and Evacuation
69.59	Other Aspiration Curettage of Uterus
70.11	Biopsy of Vulva
70.14	Other Vaginotomy (Removal of Foreign Body by Incision)
70.21	Vagenoscopy
70.33	Excision or Destruction of Lesion of Vagina

8. OPERATIONS ON THE MUSCULO-SKELETAL SYSTEM

ICD-9-CM CODE	PROCEDURE
77.54	Excision of Bunionette
77.59	Other Bunionectomy
77.60	Local Excision of Lesion or Tissue of Bone, Unspecified Site
79.02	Closed Reduction of Fracture of Radius and Ulna without Internal Fixation
79.04	Closed Reduction of Fracture without Internal Fixation (Phalanges of Hand)
79.06	Closed Reduction of Fracture of Tibia and Fibula without Internal Fixation
79.07	Closed Reduction of Fracture without Internal Fixation (Tarsals and Metatarsals)
79.13	Closed Reduction of Fracture with Internal Fixation Carpals and Metacarpals
79.32	Open Reduction with Internal Fixation
80.10	Other Arthrotomy, Unspecified Site (Hand and Foot Only)
80.20	Arthroscopy, Unspecified Site
80.60	Excision of Semilunar Cartilage of Knee
80.70	Syndvectomy, Unspecified Site
80.80	Other Local Excision or Destruction of Lesion of Joint (Arthroscopic Only)
80.90	Other Excision of Joint, Unspecified Site (Arthroscopic Only)
81.79	Other Repair of Hand and Finger
81.96	Other Repair of Joint
82.21	Excision of Lesion of Tendon, Sheath of Hand
83.14	Fasciotomy
84.30	Revision of Amputation Stump

9. OPERATIONS ON THE INTEGUMENTARY SYSTEM

ICD-9-CM CODE	PROCEDURE
85.11	Percutaneous (Needle) Biopsy of Breast
85.12	Other Biopsy of Breast
85.20	Excision or Destruction of Breast Tissue
85.21	Local Excision of Lesion of Breast
86.09	Other Incision of Skin and Subcutaneous Tissue
86.11	Biopsy of Skin and Subcutaneous Tissue
86.21	Excision of Pilonidal Cyst or Sinus
86.22	Debridement of Would, Infection, or Burn
86.23	Removal of Nail, Nailbed, or Nail Fold
86.25	Dermabrasion
86.30	Other Local Excision or Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue
86.59	Suture of Skin and Subcutaneous Tissue of Other Sites
86.84	Relaxation of Scar or Web Contracture of Skin

10. MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC PROCEDURES

ICD-9-CM CODE	PROCEDURE
93.53	Application of Other Cast
93.54	Application of Splint
96.16	Other Vaginal Dilation
97.88	Removal of External Mobilization Device

APPENDIX E

AMBULATORY SURGERY

PHYSICIAN QUESTIONNAIRE

AMBULATORY SURGERY
PHYSICIAN QUESTIONNAIRE

Keller Army Community Hospital is examining the feasibility of implementing an ambulatory surgery program. The acceptance of an ambulatory surgery program by you, the physician, is extremely important. In order to elicit your views and opinions concerning ambulatory surgery, please take time to read and answer the following questions pertaining to ambulatory surgery.

1. Have you had experience working in a structured ambulatory surgery program?

YES ☐ NO ☐

If YES, what type of surgical unit was it?

☐ HOSPITAL BASED, NONDEDICATED UNIT - This program incorporates ambulatory surgery into the existing inpatient Operating Rooms and postanesthesia Recovery Room schedule.

☐ HOSPITAL BASED, DEFINED UNIT - This program provides separate pre-operative, operative and phase II recovery areas. The initial post-anesthesia Recovery Room may be shared with inpatients.

☐ OTHER

Were you satisfied with the overall operation of the program?

YES ☐ NO ☐

If NO, what concerns did you have?

_____

_____

_____

2. Would you participate in an ambulatory surgery program by performing surgery or referring patients into the program?

YES ☐ NO ☐

If NO, please explain why.

_____

_____

_____

3. Are there any procedures not currently performed at Keller that you feel could be performed in an ambulatory surgery setting?

If YES, please list those procedures.

_____ _____

_____ _____

_____ _____

4. In the spaces provided, please indicate which factors you feel would inhibit implementing an ambulatory surgery program at Keller.

☐ Ancillary Support (i.e., lab, x-ray)

☐ Technology (specific equipment)

☐ Patient (ability to follow written protocol)

☐ Quality Assurance

☐ Staffing

☐ Other

_____

_____

_____

5. Assuming that additional resources were available, do you think that an ambulatory surgery program should be implemented at Keller?

YES ☐ NO ☐

If NO, please explain why.

_____

_____

_____

APPENDIX F

AMBULATORY SURGERY

PATIENT QUESTIONNAIRE

AMBULATORY SURGERY
PATIENT QUESTIONNAIRE

Keller Army Community Hospital is examining the feasibility of implementing an ambulatory surgery program. The acceptance of an ambulatory surgery program by you, the patient, is extremely important to us. In order to elicit your views and opinions concerning ambulatory surgery, please take time to read the following information and answer the questions pertaining to ambulatory surgery.

WHAT IS AMBULATORY SURGERY? Ambulatory surgery is defined as routinely scheduled surgery of a relatively uncomplicated nature that can be done with efficiency and safety without an overnight stay in the hospital. Patients who are selected for ambulatory surgery must be capable of understanding and willing to follow specific written instructions both before and after their surgery. In addition, the patient must have a responsible individual to take them home and help care for them once they are discharged. Some of the most common ambulatory surgery procedures are vasectomy, tonsillectomy-adenoidectomy, cystoscopy and dilatation and curettage (D&C).

1. Have you or a member of your family ever had ambulatory surgery?

YES ☐ NO ☐

IF YES, were you comfortable with the way care was provided?

YES ☐ NO ☐

IF NO, what concerns did you have about the care you received?

_____

_____

_____

2. If you were provided the written preoperative and postoperative instructions attached, do you feel that you could follow those instructions?

YES ☐ NO ☐

IF NO, please explain why.

_____

_____

_____

3. Do you have someone, a friend or relative, who could take care of you once you were discharged from the hospital?

YES ☐ NO ☐

4. How far do you live from the hospital?

☐ 1 - 10 mi ☐ 20 - 30 mi

☐ 10 - 20 mi ☐ Greater than 30 mi

5. Do you have someone, a friend or relative, who would be willing to provide your transportation to and from the hospital?

YES ☐ NO ☐

6. Based on the preceding information, would you consider having surgery of this type performed should the need ever arise?

YES ☐ NO ☐

7. What additional concerns do you have regarding ambulatory surgery?

_____

_____

_____

NAME: _____ AGE: _____ SEX: _____
(OPTIONAL)

STATUS: ☐ ACTIVE DUTY ☐ DEPENDENT

☐ CADET ☐ RETIRED

PREOPERATIVE AND PREANESTHESIA

INSTRUCTION SHEET

AMBULATORY SURGERY UNIT
KELLER ARMY COMMUNITY HOSPITAL
WEST POINT, NEW YORK 10996-1197

PREOPERATIVE INSTRUCTION SHEET

Your physician has determined that you need a brief and minor surgical procedure that will require an anesthetic. Because you are in good health and the procedure is a minor one, your surgery will be performed on an outpatient basis. This means that you will come to the Ambulatory Surgery Unit the day of the surgery and that you will be allowed to go home that afternoon. In the event that additional observation becomes necessary, you may be required to remain in the hospital overnight or until it has been deemed safe to discharge you.

These instructions have been prepared to help you understand the process for ambulatory surgery at Keller Army Community Hospital. For your safety, it is absolutely essential that you follow the instructions below:

BEFORE SURGERY:

1. Please follow all the preoperative instructions given by your doctor.
2. Come to the hospital at least two (2) days, but no more than seven (7) days, before your surgery to have your preoperative lab work completed.
3. If you are having general, regional or local anesthesia with sedation, you must arrange for a responsible adult to accompany you home on the day of surgery. For your personal safety, you will not be allowed to drive home.
4. If you develop a cold (fever, cough) or any illness before your scheduled surgery, please notify your doctor immediately.
5. DO NOT EAT OR DRINK ANYTHING, including water or MEDICATIONS, after midnight of the night before surgery. If you eat or drink anything, surgery will be CANCELLED. VOMITING AND ASPIRATION OF STOMACH CONTENTS INTO THE LUNGS MAY RESULT IN PNEUMONIA OR DEATH.

THE DAY OF SURGERY (ADULTS):

1. Wear comfortable, loose fitting clothing. Ladies, low heels please.
2. Do not wear make-up, jewelry (other than your wedding ring), nail polish, or bring valuables with you.
3. If you wear contact lenses, you must bring your case to store them during surgery.
4. Do not bring children with you.
5. Come directly to the Ambulatory Surgery Unit on the day of your surgery.
6. Arrange for a responsible adult to accompany you home and stay with you for the remainder of the day.
7. You will not be permitted to drive yourself home.

THE DAY OF SURGERY (CHILDREN):

1. You may bring children in pajamas. They may keep their underpants on.
2. For infants, you may bring formula or special drinking cups, if you wish.
3. Children may bring a favorite blanket or soft, small toy.
4. If possible, do not bring other children with you the day of surgery.
5. You may wish to arrange for an additional person to hold small infants during your drive home.

SPECIAL INSTRUCTIONS: _____

_____

_____

_____

I HAVE RECEIVED VERBALLY AND READ THE ABOVE INSTRUCTIONS. IF UNABLE TO COMPLY, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

_____	_____	_____
TIME	SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR)	DATE

_____

WITNESS

POSTOPERATIVE AND POSTANESTHETIC

INSTRUCTION SHEET

AMBULATORY SURGERY UNIT
KELLER ARMY COMMUNITY HOSPITAL
WEST POINT, NEW YORK 10996-1197

POSTOPERATIVE AND POSTANESTHETIC INSTRUCTIONS

1. Although you will be responsive soon after your anesthetic, small amounts of the anesthetic remain in the body for twenty-four (24) hours. Return home and rest for this period.

2. Nausea, vomiting, dizziness or drowsiness may be present the first 12-14 hours. If this should occur while being transported home, lie down; if at home, return to bed.

3. When you return home, follow your doctor's orders regarding medications, diet and rest. Unless instructed differently, slowly initiate clear liquids and continue for six (6) hours after surgery, then light meals until morning. If you are taking an oral pain medication, do not take it on an empty stomach or consume any alcohol.

4. Tasks that require physical or mental alertness should not be attempted for twenty-four (24) hours. DO NOT drive a car, sign any legal documents or engage in any legal transactions during this time.

5. It is advisable to have someone home with you the rest of the day.

6. Any postoperative problems related to your surgery and/or anesthesia, i.e., bleeding, fever, persistent nausea, vomiting or inability to void within eight to twelve (8-12) hours, call Dr. _____ at _____. If unable to reach your physician with an urgent or severe problem call the emergency room at 938-4004 or 4006.

7. Call _____ for a follow-up appointment in _____ days/weeks/months.

8. For your convenience, all prescriptions may be filled at our pharmacy before leaving.

_____

_____

_____

_____

(Record dosage, schedule and duration of each drug)

9. Other Instructions: _____

_____

_____

10. I have read and discussed the above instructions with the nurse/doctor, and I understand them.

_____ _____

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR) DATE

_____ _____

PERSON GIVING INSTRUCTIONS DATE

_____ _____

ACCOMPANYING ADULT'S SIGNATURE DATE

APPENDIX G

WORKLOAD ANALYSIS OF

INPATIENT SURGICAL PROCEDURES

THAT QUALIFY AS POTENTIAL AMBULATORY SURGERY PROCEDURES

PROCEDURE	NUMBER OF PROCEDURES PERFORMED	BED DAYS GENERATED	MCCUs PRODUCED
Release of Carpal Tunnel	6	12	72
Mucosal Graft	1	3	13
Operations on Cornea	1	1	11
Extracapsular Extraction of Lens	7	26	96
Recession of One Extraocular Muscle	2	4	24
Operations on Two More Extraocular Muscles Involving Temporary Detachment from Globe, One or Both Eyes	2	4	24
Myringoplasty	2	4	24
Myringotomy with Insertion of Tube (Insertion of Tympanotomy Tube)	7	10	80
Closure of Nasal Sinus Fistula	2	3	23
Tonsillectomy without Adenoidectomy	8	16	96
Tonsillectomy with Adenoidectomy	3	6	36
Adenoidectomy without Tonsillectomy	4	8	48
Laryngoscopy and other Tracheoscopy	1	2	12
Thoracentesis	1	1	11
Biopsy of Bone Marrow	2	3	23
Biopsy of Esophagus	1	1	11
Colonscopy	3	3	33
Endoscopy of Large Intestine	6	8	68
Anal Fistulotomy	2	10	30
Excision of Hemorrhoids	3	12	42
Repair of Hernia or Anterior Abdominal Wall	1	5	15
Laparoscopy	8	24	104
Cystoscopy	4	7	47
Transurethral Excision or Destruction of Lesion or Tissue of Bladder	2	4	24
Release of Urethral Structure	2	5	25
Needle Biopsy of Prostate	1	1	12
Other Biopsy of Prostate	3	3	36
Excision of Varicocele and Hydrocele of Spermatic Cord	3	3	38
Vasectomy	1	1	12
Circumcision	5	5	60
Dilation and Curettage	7	7	81
Dilation and Evacuation	5	5	55
Bunionectomy	5	5	69
Local Excision of Lesion or Tissue of Bone, Unspecified Site	1	1	12
Closed Reduction of Fracture of Radius and Ulna without Internal Fixation	1	1	11
Closed Reduction of Fracture without Internal Fixation (Phalanges of Hand)	1	1	11
Closed Reduction of Fracture of Tibia and Fibula without Internal Fixation	1	1	12
Open Reduction without Internal Fixation	3	5	35
Arthrotomy, Unspecified Site (Hand and Foot Only)	1	2	12

PROCEDURE	NUMBER OF PROCEDURES PERFORMED	BED DAYS GENERATED	MCCUs PRODUCED
Arthroscopy	44	98	538
Division of Joint Capsule, Ligament, or Cartilage, (Arthroscopic, Hand and Foot Only)	1	3	13
Excision of Semilunar Cartilage of Knee	15	30	180
Excision of Joint, Unspecified Site (Arthroscopic Only)	4	8	48
Other Repair of Hand and Finger	1	3	13
Excision of Cyst	1	2	12
Revision of Amputation Stump	1	4	14
Biopsy of Breast	5	11	61
Local Excision of Lesion of Breast	2	4	24
Incision of Skin and Subcutaneous Tissue	3	10	40
Removal of Nail, Nailbed, or Nail Fold	2	4	24
Dermabrasion	1	3	13
Other Local Excision or Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	3	[illegible]	36
Application of Cast	3	[illegible]	39
Application of Splint	1	1	11
TOTAL NUMBER OF PROCEDURES	206	TOTAL BED DAYS 454	TOTAL MCCUs 2514

APPENDIX H

WORKLOAD ANALYSIS OF CLINICAL PROCEDURES THAT QUALIFY AS AMBULATORY SURGERY PROCEDURES

PROCEDURE	NUMBER OF PROCEDURES PERFORMED	CLINIC MCCUs PRODUCED
Biopsy of Vulva	14	4.2
Excision or Destruction of Lesion or Tissue of Cervix	4	1.2
Vagenoscopy	2	.6
Removal of Vaginal Disphragm	2	.6
Uterine Biopsy	41	12.3
Other Excision or Destruction of Lesion of Uterus	7	2.1
Biopsy of Breast	14	4.2
Local Excision of Lesion of Breast	19	5.7
Excision or Destruction of Breast Tissue	5	1.5
Excision of Lesion of Tendon, Sheath of Hand	1	.3
Cystoscopy	73	21.9
Other Dilation and Curettage	4	1.2
Vasectomy	19	5.7
Other Diagnostic Procedure on Seminal Vesicles	16	4.8
Endoscopy of Large Intestine through Stoma (Artificial)	47	14.1
Other Incision of Skin and Subcutaeneous Tissue	7	2.1
Other Endoscopy of Large Intestine	13	3.9
Other Operations on Eyelids	7	2.1
Biopsy of Iris	2	.6
Other Removal or Destruction of Corneal Lesion	3	.9
Excision of Chalazion	8	2.4
Removal of Lesion of Eyelid, Not Otherwise Specified	2	.6
Other Eyelid Repair	1	.3
Excision of Minor Lesion of Eyelid	1	.3
TOTAL PROCEDURES	312	TOTAL MCCUs 93.6

APPENDIX I

SITE APPROVAL

HSUD (HSUD/6 Apr 87)
SUBJECT: Ambulatory Surgery Site Selection

TO Admin Resident FROM Cdr, MEDDAC DATE 20 Apr 87 CMT 2
COL Wolcott/ad/3305

For planning purpose only, the Delivery Room on the Obstetrics Ward is approved as the proposed site for the Ambulatory Surgery Unit.

2 Encls
nc

BARRY W. WOLCOTT
Colonel, MC
Commanding

DISPOSITION FORM

For use of this form, see AR 340-15, the proponent agency is TAGO.

96

REFERENCE OR OFFICE SYMBOL	SUBJECT
[illegible]	Ambulatory Surgery Site Selection

TO: Cdr, MEDDAC

FROM: Admin Resident

DATE: 6 Apr 87

CMT: CPT Porter/ssl/4300

1. FOR DECISION.

2. PROBLEM: To determine the best location within Keller Army Community Hospital in which to locate the Ambulatory Surgery Unit.

3. RECOMMENDATION: That Alternative II be approved as the site for the Ambulatory Surgery Unit.

4. FACTS BEARING ON THE PROBLEM:

a. HSC PAM 40-7-3, dated 13 August 1986, Subject: Same-Day-Surgery provided guidance to all USA Health Services Command Medical Treatment Facilities where ambulatory surgery programs have been implemented or where the potential for such a program exists.

b. Headquarters, Department of the Army Letter 40-86-6, dated 31 December 1986 directs the implementation of same-day-surgery in Army Medical Treatment Facilities where it is cost effective to do so.

c. The Surgeon General has directed that Diagnosis Related Groups (DRGs) be implemented in the Army effective 1 October 1987.

5. DISCUSSION:

a. The present surgical treatment system exists entirely within the realm of traditional hospitalization. There is no formal preadmission testing program whereby the patient can accomplish most of the testing and administrative requirements before the actual day of hospitalization. Essentially, all major and minor surgical procedures are preceded by a day of hospitalization.

b. Should an ambulatory surgery program be implemented at Keller, the only feasible type of program would be a hospital-affiliated unit. Hospital affiliated refers to a unit associated with the hospital. Characteristically, this type of program can be established with little capital investment and use present staff, facilities and support services. As such, there are two alternatives available to Keller in establishing such a program.

a. ALTERNATIVE 1 - HOSPITAL BASED, NONDEDICATED UNIT: This program would incorporate ambulatory surgery into the inpatient operating room and postanesthesia recovery schedule and routine. Patients would be prepared for surgery in a separate preoperative area (MSU) even though the surgery will be performed in the main Operating Rooms and initial (phase I) recovery in the main postanesthesia Recovery Room. The patient would then be taken to a second-stage recovery area (back to MSU), where he/she is reunited with his/her family, allowed progressive ambulation, given postoperative instructions and discharged. The primary advantages and disadvantages of this type of program are listed below.

☆ U.S. Government Printing Office: 1983—406-862

H) CMT 1
SUBJECT: Ambulatory Surgery Site Selection

ADVANTAGES	DISADVANTAGES
1. Utilizes existing facilities. 2. Centralization of surgery. 3. Staff convenience.	1. Scheduling - inpatients may be given priority and ambulatory surgery patients bumped from the surgical schedule. 2. Increased chance of nosocomial infections since they would be exposed to "sick" patients on MSU. 3. Does not free-up Operating Rooms for more complex surgical procedures. 4. Distance between Operating Room/Recovery Room and MSU.

b. ALTERNATIVE 2 - HOSPITAL BASED, DEFINED UNIT: The Ambulatory Surgery Unit would be located within the hospital on the Obstetrics Ward. The patients would be prepared for surgery in a separate preoperative area (RM 304), taken to surgery in the Operating Room located on the OB ward and initial (phase I) recovery in the main postanesthesia Recovery Room. Once discharge criteria from the Recovery Room was met, the patient would be taken back to room for phase II recovery. There the patient is reunited with their family, allowed progressive ambulation, given postoperative instructions and discharged. The primary advantages and disadvantages of this type of program are listed below.

ADVANTAGES	DISADVANTAGES
1. Dedicated space for unit. 2. No competition for inpatient operating rooms. 3. Easier scheduling of patients (less bumping). 4. Frees up main Operating Rooms for more complex procedures. 5. Less chance of nosocomial infections since the patient is not exposed to "sick" patients. 6. Free-up MSU nursing staff from a labor-intensive task. 7. Seperate area on the same floor as patient for family members to wait.	1. Additional staffing required - one nurse - augment main recovery room; one nurse for phase II recovery; one corps man; and one records clerk. 2. Surgery not centralized in one area. 3. Less convenient for staff. 4. Splits anesthesia staff.

Some concerns have been expressed as to whether or not the Delivery Room is adequately equipped for the use of anesthesia. On 12 March 1987, a survey was conducted by Mr. Dan Voglesong, the Industrial Hygienist, of the Delivery Room. The results of that survey are attached.

6. RESOURCE IMPACT: In order to implement Alternative II, additional staffing or augmentation from existing staff would be necessary. The following personnel requirements have been identified: one nurse to augment the main Recovery Room; one nurse to operate the Ambulatory Surgery Unit/phase II Recovery Room; one corpsman to assist in operating the Surgical Unit; one records clerk to help insure proper maintenance of records.

i. JD CMT 1
SUBJECT: Ambulatory Surgery Site Selection

7. COORDINATION:

DCCS	concur/~~nonconcur~~	Signature	David E. Smith	Date 7 Apr 87
C, DoN	concur/~~nonconcur~~	Signature	James W. Hayton	Date 9 Apr 87
C, PAD	concur/~~nonconcur~~	Signature	Thomas K. Jones	Date 7 Apr 87
C, CSD	concur/~~nonconcur~~	Signature	J. D. Greenwood	Date 7 April 87

2 Atchs
1. Vent Survey DF
2. DoN Recommend DF

BILLY R. PORTER
CPT, MS
Administrative Resident

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

99

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSUD-PM	OBU, Delivery Room #3 - Ventilation Survey

TO THRU C,PVNTMEDS FROM Daniel Voglesong, Industrial Hygienist DATE 20 March 1987 CMT 1 dmb/2205

TO DCA, MEDDAC

1. On 12 March 1987, I conducted a ventilation survey of Delivery Room #3 with PV2 Robert Brightmon, Preventive Medicine Service Specialist,for the potential use of nitrous oxide as anesthesia during surgery.

2. SSG Junkins, Bio-Medical Repair Specialist, and LTC Soltau, AN, anesthetist, conducted a simulated use of the Ohio 30/70 anesthesia machine at 0930 hours.

3. Using the MIRAN 103 Infrared Vapor Analyzer, I measured less than 10 ppm nitrous oxide at a point 2 feet from the anesthesia machine. This concentration meets the standard of 25 ppm nitrous oxide of the Criteria Document: Occupational Exposure to Waste Anesthetic Gases (TB MED 510).

4. Using an ALNOR Velometer, I measured the air velocity at all 4 vents in the room which had an average flow rate of 390 feet/minute (FPM). These 4 vents pull a total of 39,312 cubic feet of air/hour which is a room air exchange rate of 20.0 air changes/hour. This air exchange rate exceeds the recommended 15 air changes/hour, (ETL-1110-3-344, Oct 83).

5. Based on these survey results, the Ohio 30/70 Anesthesia Machine can be safely used to anesthetize patients with nitrous oxide in Delivery Room #3, during surgery.

Daniel P. Voglesong

DANIEL P. VOGLESONG
Industrial Hygienist

+ctl

DA FORM AUG 80 2496 PREVIOUS EDITIONS WILL BE USED

* USGPO 1988-490-003/43241

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

100

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSUD-HN	Ambulatory Surgery Site Selection

TO Administrative Resident FROM C, DON DATE 8 April 1987 CMT 1

LTC Heston/bm/4834

1. In response to your study on Ambulatory Surgery Site Selection, the following is submitted.

2. Recommend Alternative 2.

3. Alternative 1 would have been preferable because it would allow use of existing facilities and procedures. A major disadvantage not mentioned is that it would need additional staff on MSU dedicated to this program. Staff currently assigned to MSU is stretched to the limit and could not take on this major additional program. I believe this alternative is not a viable option because it would require large scale cooperation among the surgeons to free up time on the O.R. schedule in order to make room for this program. This is not likely to occur with current players.

4. Despite the broad based unpopularity of Alternative 2, it is the preferable way to go. It would make better use of space and specialty equipment. You acknowledge that additional personnel would be required. It must be stressed in the presentation to the Commander, that the organization cannot tolerate taking these personnel out of its hide.

5. An unlikely third alternative would be to petition HSC to drop OB from our mission. In the almost four years I have been assigned to KACH, I have seen the average monthly delivery rate drop from 25+ in 1983 to 20.5 over the past 6 months. I have been unable to hire a civilian OB nurse since October. This situation will become worse when 1.5 more nurses move in May. ANC Career Activities will probably not be able to send a 66G AOC replacement for the departing OB Head Nurse. With ambulatory surgery as a wave of the future, a 20% drop in the OB unit's patient care needs and continuing difficulty in filling OB specialty authorized positions, I recommend that the OB service should be converted to an Ambulatory Surgery service with transfer of all space, equipment and personnel to that mission change.

JAMES V. HESTON
LTC, AN
Chief, Department of Nursing

HSUD

TO Cdr, MEDDAC FROM Admin Resident DATE 9 April 1987 CMT 2

CPT Porter/ssl/4300

1. Based on discussion with both the Chief, Department of Nursing and the Chief, Patient Administration Division, only one additional Registered Nurse would need to be hired in order to begin the program. The rest of the staff would come from existing hospital assets.

2. The additional cost of hiring a Registered Nurse at $22,458 a year will have to be taken into consideration in determining the actual costs/benefits of the program.

BILLY R. PORTER
CPT, MS
Administrative Resident

DA FORM 2496 PREVIOUS EDITIONS WILL BE USED * USGPO 1986-490-003/43241

APPENDIX J

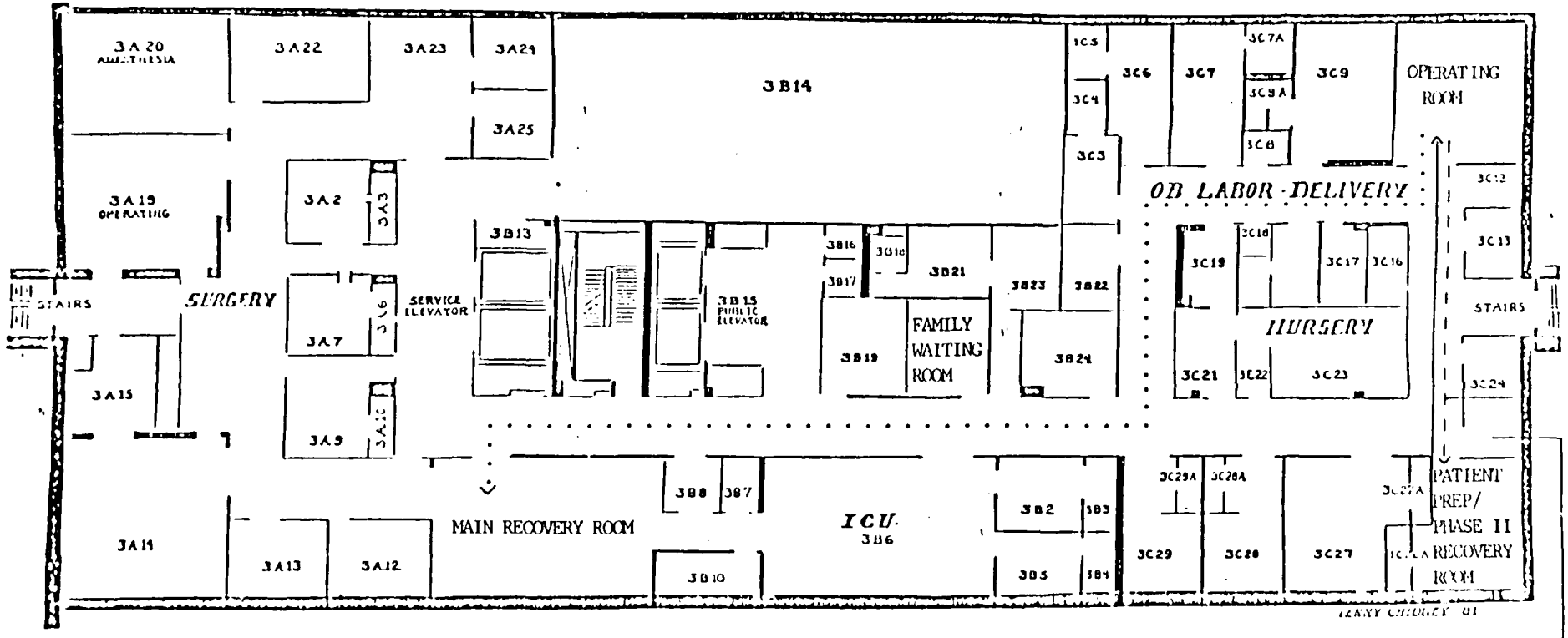
PATIENT FLOW THROUGH SURGICAL UNIT

LEGEND:

_____PATIENT FLOW TO THE OPERATING ROOM

_ _ _ _ _ _PATIENT FLOW TO PHASE II RECOVERY ROOM

. . . . . .PATIENT FLOW TO PHASE I RECOVERY ROOM



APPENDIX K

ADMISSIONS SOP

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

ADMISSIONS SOP

1. Purpose: This SOP establishes procedures and responsibilities for the pre-admission and disposition of ambulatory surgery patients in the Keller Army Community Hospital.

2. Objective:

a. To reduce the amount of administrative processing required at the time of admission.

b. To reduce the length of inpatient stay through the maximum use of outpatient resources prior to admission.

3. Applicability: The provisions of this SOP apply to all personnel involved in the pre-admission of ambulatory surgery patients to Keller Army Community Hospital.

4. Responsibilities:

a. Clinic Physician/Receptionist

(1) Informs the patient of the need for surgery, obtains consent, schedules the procedure with the Operating Room and Informs the patient of the date and time of surgery.

(2) Completely fills out:

(a) Abbreviated medical record (SF 539)

(b) Doctor's Order Sheet (DA FORM 4256) with

(1) Admit to Ambulatory Surgery Unit

(2) Routine lab requests (CBC, UA and other lab tests will be done only when medically indicated) stamped with ASU and date of surgery.

(3) Chest X-ray and EKG for patients over 40 when undergoing general anesthesia or when indicated.

(c) Operation request and Worksheet (DA FORM 4107)

(d) Anesthesia and operative permit (SF 522)

(e) Preadmit/Admission Note

(3) Provide the patient with a preoperative instruction sheet indicating the date of surgery and the time of his/her arrival at the Ambulatory Surgery Unit.

(4) Insures that the patient's chart is complete and reaches the Ambulatory Surgery Unit at least one (1) day prior to surgery.

(5) Directs the patient to the Admission and Disposition Branch located on the first floor of Building 900, main entrance to the hospital.

b. Admissions and Dispositions:

(1) Prior to surgery:

(a) Interview the patient to collect the required information necessary to prepare the IAR.

(b) Produce admissions documents as required. A pre-register number will be assigned. A white inpatient recording card and buff patient control card produced and returned to the clinic by the patient.

(c) Verbally confirm the specified admission date with the patient.

(d) Initiate a pre-admission suspense file maintained by projected admission date sequence and alphabetically within each date.

(e) File all the pre-admission documents in the pre-admission suspense file.

(f) If required, direct the patient to the appropriate area for pre-operative testing.

(g) Directs the patient to the Ambulatory Surgery Unit located on the third floor.

(2) Day of surgery:

(a) Provide the patient with their armband and direct them to the Ambulatory Surgery Unit.

(b) If the pre-admission is rescheduled, the A&D clerk will move the patient's folder to the new date in the pre-admission suspense file.

(c) Discharge patient once released from surgical unit in accordance with discharge protocol.

c. Head Nurse ASU:

(1) Conducts a nursing care assessment of the patient.

(2) Provides the patient with an appointment date, time and place to report for anesthesia interview. (It may be appropriate that the post-anesthesia counseling take place at this time. The physical status and geographic location of the patient's domicile will be the primary factor in determining when the anesthesia counseling will be accomplished.)

(3) Reinforce instructions provided by the physician for pre-surgical care.

(4) Verbally confirm the date and time the patient will return to the unit.

APPENDIX L

PATIENT SELECTION CRITERIA

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

PATIENT SELECTION CRITERIA

SELECTION OF PATIENTS: The patient's well-being must always be the main consideration in selecting patients for ambulatory surgery. It is the physician's responsibility to identify patients who qualify for the ambulatory surgery program. A number of factors, however, interact and influence patient suitability. These factors should be considered before making this choice.

(1) SIMPLICITY OF THE PROCEDURE: The operative procedure must be of short duration (one hour or less) and entail only minimal bleeding or minor psysiological derangements.

(2) INCIDENCE OF POSTOPERATIVE COMPLICATIONS: This is an important restriction in the selection of the patient. The incidence of postoperative complications should be relatively low; however, some amount of physiological change and discomfort must be expected.

(3) GENERAL GOOD HEALTH OF THE PATIENT: The patient should be free of major uncontrolled medical problems. Existing medical problems must be investigated and stabilized prior to the operation. For the purposes of anesthesia, only American Society of Anesthesiologists (ASA) Class I and II patients will be considered as suitable for ambulatory surgery. The classification guidelines of these two categories of patients reads as follows:

CLASS I: No organic, physiologic, biochemical or psychiatric disturbance.

CLASS II: Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes, e.g., epilepsy controlled by medication; or mild hypertension controlled on therapy.

(4) RELIABILITY OF THE PATIENT: The patient must be capable of understanding, and certainly must be willing to follow specific instructions regarding the surgical procedure. The patient must also understand that they need to have a responsible adult take them home after the surgery is completed.

(5) PSYCHOLOGICAL ACCEPTANCE BY THE PATIENT: Patients must be motivated to have the procedure performed in an ambulatory surgery clinic. The patient must be psychologically suitable and prepared to accept a shortened hospital stay. On the other hand, patients should be aware that in some cases they may have to remain in the hospital overnight. All patients need reassurance that they will be discharged only if they meet the necessary medical criteria and can manage their own care.

(6) AGE AND HOME SITUATION OF THE PATIENT: This must be carefully considered when evaluating a patient for ambulatory surgery. For example,

a. Elderly individuals are often not suitable for ambulatory surgery because there is no one to take care of them when they return home following surgery.

b. Active duty personnel living in the barracks and undergoing a general anesthetic will not be accepted for ambulatory surgery.

c. Cadets will not be accepted for ambulatory surgery.

d. Children under one year of age must be cleared by the anesthesiologist before scheduling.

(7) COOPERATION BY THE SURGEON: There must be cooperation by the surgeon in understanding and agreeing to the criteria above. If an anesthetic is required, the Chief of Anesthesiology will have the final authority to accept or reject a patient for surgery since he/she is the best qualified for evaluating the anesthetic risk for patients.

APPENDIX M

SOP FOR THE

PREPARATION, USE AND CONTROL OF DRUGS

USED IN AMBULATORY SURGERY UNIT

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

PREPARATION, USE AND CONTROL OF DRUGS

1. Purpose: To establish policies and procedures for the preparation, use and control of drugs and controlled substances used in the Ambulatory Surgery Unit.

2. Objective: To familiarize both the surgical staff and ambulatory surgery staff on the proper preparation, use and control of drugs used during surgery.

3. Applicability: The provisions of this SOP apply to all personnel assigned to the Operating Room staff and Ambulatory Surgery unit.

4. Responsibilities For:

a. Drug Preparation and Use

(1) All drugs for intravenous and injection use will be prepared by a nurse.

(2) If the drug(s) or solution(s) have been prepared in the Operating Room, the empty vials should remain in the Operating Room until the surgery is completed and the patient taken to an appropriate recovery area.

(3) Both the scrub technician and circulator will verify the drug prior to it being poured.

b. Narcotics and Controlled Drugs:

(1) These drugs are maintained and secured by the Anesthesia Department.

(2) The Narcotics will be brought to the Ambulatory Surgery Unit each morning by the Anesthetist.

(3) At the end of the day, the Narcotics are to be returned to the main Operating Room. The procedures for accountability in the Ambulatory Surgery Unit will be identical to the method used in the main Operating Room.

APPENDIX N

RECOVERY ROOM DISCHARGE SOP/CRITERIA

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

RECOVERY ROOM DISCHARGE SOP

1. Purpose: To establish guidelines for the safe discharge of patients from the Main/Phase II Recovery Room.

2. Objective: To insure that patients are afforded the safest possible care while in Keller Army Community Hospital.

3. Applicability: The provisions of this SOP apply to all personnel working within the Main/Phase I Recovery Room.

4. Responsibilities:

a. Physician:

(1) Insure that appropriate Recovery Room instructions accompany each patient, i.e., any medication orders.

(2) Insure that postoperative instructions and any additional items such as follow-up appointments are entered on the Doctor's Orders Sheet.

b. Recovery Room Head Nurse:

(1) Insure that patients remain in the Recovery Room until transfer criteria have been met (see attached sheet). Every patient must have a score of eight or above before being transferred.

(2) Records the patient's postanesthetic score in the Recovery Room record.

(3) Notifies the Anesthesiologist of patients recovery score.

(4) Transfers the patient to the Phase II Recovery Area once the transfer criteria has been met and permission granted by the Anesthesiologist. NOTE: A discharge order will not be written until just prior to the patient's discharge from the Recovery Room.

c. Anesthesiologist:

(1) Examines and discharges patients once they meet discharge criteria.

(2) Documents the reason for discharge of patients with a score of less than eight.

(3) Notify surgeon of those patients that may require transfer to the Intensive Care Unit or the Medical/Surgical Unit (MSU) for further care.

POSTANESTHETIC RECOVERY SCORE

Activity	Score
Able to move four extremities voluntarily or on command	2
Able to move two extremities voluntarily or on command	1
Able to move 0 extremities voluntarily or on command	0
Respiration	
Able to deep breathe and cough freely	2
Dyspnea or limited breathing	1
Apneic	0
Circulation	
BP +/- 20% of preanesthetic level	2
BP +/- 20-50% of preanesthetic level	1
BP +/- 50% of preanesthetic level	0
Consciousness	
Fully awake	2
Arousable on calling	1
Not responding	0
Temperature	
Axillary temperature is higher than 96°F	2
Axillary temperature is 95° to 96°F	1
Axillary temperature is less than 95°F	0

TOTAL SCORE ___

APPENDIX O

DISCHARGE GUIDLLINES

FOR THE AMBULATORY SURGERY UNIT

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

DISCHARGE GUIDELINES FOR THE AMBULATORY SURGERY UNIT

1. Purpose: To establish guidelines for the discharge of patients from the Ambulatory Surgery Unit.

2. Objective: To insure that patients are afforded and receive the safest possible care while in Keller Army Community Hospital.

3. Applicability: The guidelines contained in this paper apply to all personnel involved in the care and treatment of ambulatory surgery patients.

4. General:

a. Approximately two (2) hours after being administered the anesthetic, the patient should be eligible for discharge. Eligibility for an earlier discharge is possible provided the procedure is relatively minor, the anesthesia time is less than thirty (30) minutes and the remaining discharge criteria are met. The following criteria will be used in the evaluation of the patient:

(1) An uncomplicated anesthetic and an uncomplicated Recovery Room stay;

(2) Alert and oriented to time and place;

(3) Stable vital signs for at least one-half hour;

(4) No pain not controllable by oral analegesics;

(5) No emesis; nausea mild is present;

(6) No bleeding from the operative site;

(7) Able to void;

(8) Able to retain clear fluids;

(9) Able to walk without dizziness, and;

(10) The presence of a responsible adult to accompany the patient home.

b. Prior to discharge the patient will be examined by a qualified physician and a note describing the patient's condition will be placed in the progress notes of the patient's record. The order to discharge the patient will be written at that time. The patient will then receive:

(1) A postoperative precaution sheet which will be discussed with the patient by a professional member of the Ambulatory Surgery unit's staff;

(2) Prescription(s) for any medication(s) ordered;

(3) A list of postoperative instructions written by the surgeon;

(4) A list of phone numbers to call should any pertinent questions arise or an emergency occur, and;

(5) A follow-up appointment if appropriate.

c. When a patient does not meet the criteria for discharge, they will be admitted to the Medical/Surgical Unit as an inpatient. It is the responsibility of the attending physician to notify the Admissions Office and write the order for admission. The ambulatory surgery record will be sent to the ward as an "old record". Upon arrival on the Nursing Ward, an inpatient record will be initiated.

APPENDIX P

QUALITY ASSURANCE POLICY AND PROCEDURES

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

AMBULATORY SURGERY QUALITY ASSURANCE PROGRAM

1. Purpose: To objectively, systematically and comprehensively monitor and evaluate the quality and appropriateness of patient care; to reveal opportunities for improving patient care; and to resolve identified problems.

2. Applicability: The provisions of this SOP apply to all hospital personnel involved in the care and monitoring of ambulatory surgery patients.

3. Objectives:

a. To provide high quality patient care;

b. To improve documentation and accountability;

c. To improve intra- and interdepartmental communication, and;

d. To provide data for staff development needs, i.e., continuing education programs specific to the function of the Ambulatory Surgery Unit.

4. Responsibility:

a. Chief, Department of Surgery

(1) Accepts accountability and responsibility for the provisions of the Quality Assurance Program within the Ambulatory Surgery Unit.

(2) Assures that the Quality Assurance process is implemented by a monthly review of the quality and volume indicators and that process is effective.

(3) Assures the implementation of ongoing follow-up activities to ensure the desired results are being achieved and sustained.

b. Ambulatory Surgery Unit Head Nurse

(1) Identifies potential problems or related concerns in the delivery of care to the patient. When a problem in patient care or an opportunity to improve care is identified, an unusual occurrence report will be generated or the concern may be expressed through other appropriate QA channels, to include the hospital QA Coordinator. QA findings and conclusions related to the Nursing Department will be reported to the Nursing Quality Assurance Committee.

(2) Implements appropriate actions to resolve, insofar as possible, identified problems and concerns.

(3) Monitors activities being implemented to ensure the desired results are being achieved and sustained.

(4) Documents the effectiveness of an organized and well-defined program to enhance patient care. A Quality Assurance indicator tool will be maintained daily by the head Nurse, Ambulatory Surgery. Statistics will be monitored and evaluated on a daily, weekly and monthly basis in order to identify and resolve any potential problem area (see attached sheet).

c. Quality Assurance Coordinator:

(1) Monitor the effectiveness of the program.

(2) Help resolve identified problems and concerns.

(3) Review on an annual basis the unit's quality assurance program.

KELLER ARMY COMMUNITY HOSPITAL
AMBULATORY SURGERY UNIT
QUALITY OF CARE/SERVICE REPORT

DATE_____ 19____

INDICATORS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
A. VOLUME												
1. Number of patients												
2. Total # of procedures												
a. Ophthalmology												
b. General Surgery												
c. Urology												
d. Orthopedic												
e. GYN												
f. EENT												
B. QUALITY												
1. Number of waits equal to more than one (1) hour												
2. Number of patients admitted post-procedure												
a. Anesthesia Related												
b. Procedure extended beyond ASU scope												
c. Miscellaneous												
3. Delays in results												
a. Laboratory												
b. X-ray												
c. EKG												
4. Cancellations												
a. Abnormal Test Values												
b. Rescheduled												
c. Inappropriate for ASU												
d. Miscellaneous												
5. Delay in discharge												
a. Slow recovery												
b. Complications												
c. Escort not available												
d. Miscellaneous												
6. Follow-up Phone Call												
a. Unable to reach by phone												
b. Minor Complication												
c. Major Complication												
d. M.D. not notified of Complication												
7. Incident Reports												
a. Medication Errors												
b. Falls												
c. Miscellaneous												
8. Patient/Family Complaints												

KELLER ARMY COMMUNITY HOSPITAL
AMBULATORY SURGERY UNIT
DAILY QUALITY OF CARE/SERVICE REPORT

)ATE _____ 19____ (ENTER APPROPRIATE NUMBER EACH DAY)

INDICATORS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
A. VOLUME																															
1. Number of Patients																															
2. Number of Admissions																															
3. Total number of procedures																															
a. Ophthalmology																															
b. General Surgery																															
c. Urology																															
d. Orthopedic																															
e. GYN																															
f. EENT																															
B. QUALITY																															
1. Number of warts equal to more than one (1) hour																															
2. Number of patients admitted post-procedure																															
a. Prolonged anesthesia																															
b. Failure to recover from anesthesia																															
c. Preoperative medical history requiring postoperative monitoring																															
d. Procedure extended beyond ASU scope																															
e. Miscellaneous																															
3. Delays in results																															
a. Laboratory																															
b. X-ray																															
c. EKG																															
4. Cancellations																															
a. Abnormal test values																															
b. Rescheduled																															
c. Inappropriate for AS																															
d. Miscellaneous																															
5. Pre-Anesthesia record completed																															
6. Post-Anesthesia record completed																															
7. No M.D. orders and/or History and Physical																															

KELLER ARMY COMMUNITY HOSPITAL
AMBULATORY SURGERY UNIT
DAILY QUALITY OF CARE/SERVICE REPORT

)ATE_____19____ (ENTER APPROPRIATE NUMBER EACH DAY)

INDICATORS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8. Delay in discharge																															
a. Slow recovery																															
b. Complications																															
c. Escort not available																															
d. Miscellaneous																															
9. Follow-up Phone Call																															
a. Reached by phone																															
b. Unable to reach by phone																															
c. Minor complication																															
d. Major complication																															
e. M.D. notified of complication																															
10. Incident Reports																															
a. Medication errors																															
b. Falls																															
c. Miscellaneous																															
11. Patient/Family Complaints																															
12. Physician/Staff Complaints																															

APPENDIX Q

ANESTHESIOLOGY SOP FOR

AMBULATORY SURGERY

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

SOP FOR ANESTHESIOLOGY

1. Purpose: To establish policies within the Anesthesia Department to ensure that patients receive the safest possible care while in Keller Army Hospital.

2. Objectives:

a. To ensure a safe and controlled environment exists within the Ambulatory Surgery Unit.

b. Educate all employees as to their duties and responsibilities pertaining to ambulatory surgery patients.

3. Applicability: The provisions of this SOP apply to all personnel assigned to the Anesthesia Department who are involved in the care and treatment of ambulatory surgery patients.

4. Responsibilities:

a. Preoperative Interview:

(1) Evaluate each patient scheduled for a surgical procedure regardless of the type of anesthesia planned.

(2) Inform the patient regarding the risks and alternatives to anesthesia.

(3) Write a standard preoperative note in the progress notes or anesthesia record.

(4) Cancel patients who do not meet the criteria for ambulatory surgery.

(5) Contact the surgeon when a patient has been cancelled in order that the patient be placed on the main Operating Room schedule.

b. Day of Surgery:

(1) Prepare all equipment, supplies and medications necessary for the day's case load.

(2) Inspect the anesthesia machine to ensure that the proper masters, tubes and bags are present and that the machine is in good working order.

(3) Verify proper identification of the patient by use of the identification band and verbal response.

(4) Review chart for completeness - signed consent and results on all lab/diagnostic tests ordered.

(5) Start IV's if not done by ambulatory surgery staff.

c. Recovery:

(1) Give a verbal report to the Head Nurse or her designee upon arrival in the Recovery Room.

(2) Clear patients for transfer when the discharge criteria has been met.

(3) Record postoperative anesthesia note.

(4) Write orders as necessary regarding postoperative patient instruction relating to anesthesia.

APPENDIX R

SAFETY SOP

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

SAFETY SOP

1. Purpose: To establish policies within the Ambulatory Surgery Unit to ensure that both patients and staff are afforded the safest possible environment while in Keller Army Community Hospital.

2. Objectives:

a. To reduce risk-creating safety violations and incidents that adversely affect patients and employees.

b. Educate all employees as to duties and responsibilities regarding safety.

3. Applicability: The provisions of this SOP apply to all persons, personnel and patients utilizing the Ambulatory Surgery Unit.

4. Responsibility:

a. General:

(1) All personnel assigned or authorized access to the Ambulatory Surgery Unit will familiarize themselves with the provisions of this SOP.

(2) Anyone observing an unsafe act will make on-the-spot corrections to ensure good safety practices are maintained.

b. Staff:

(1) Employee Education/Safety

(a) Movement Procedures. Proper techniques for moving patients will be identified and explained. Specific instructions on the proper use of body mechanics will be provided and demonstration of common hallway and room hazards will be accomplished by the supervisor of the Ambulatory Surgery Unit.

(b) Identification Procedures. Proper techniques for identifying patients before the administration of medications will be explained.

(c) Instrument and Equipment Handling Procedures. Proper use of instruments will be explained and discussed. Procedures as to the proper handling, use, storage, and troubleshooting of specific instruments will also be demonstrated.

c. Medication and Treatment Safety:

(1) All medications will be identified under lighted conditions.

(2) All medications will be given from clearly marked containers.

(3) All medication directions will be followed at all times.

(4) Narcotics and poisons will be secured and out of the patient's sight.

d. Patient's Safety:

(1) Take precautions to prevent patients from falling out of bed. Bed rails should be used on elderly patients, patients who are restless or unconscious and patients who have received a pain medication.

(2) Assist patients who have trouble getting in and out of bed.

(3) Make the bedside call bell readily available for the patient.

(4) Provide adequate support in lifting patients. Remember, always get someone to help when moving or lifting a heavy patient.

(5) Use safety straps on wheelchairs and gurneys when transporting patients.

(6) Keep bed wheels in the locked position.

e. Reception/Ambulatory Surgery Unit/Operating Room:

(1) Smoking will not be permitted in either area.

(2) Defective electrical equipment will not be used. Faulty equipment will be tagged and reported to the supervisor who will notify Bio-Medical Maintenance.

(3) Unauthorized personnel will not be permitted in the Operating Room.

APPENDIX S

SCHEDULING SOP

FOR AMBULATORY SURGERY

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996-1197

SCHEDULING SOP

1. Purpose: To provide a standard method of assuring proper patient scheduling for the Operating Room in the Ambulatory Surgery Unit.

2. Objectives: To familiarize the clinics and Operating Room staff of the proper scheduling procedures.

3. Responsibility: The physicians, secretary or NCOIC of each clinic may schedule patients.

Procedure: 1. Physicians, clinic NCOICs and secretaries may call the main Operating Room at 2061 to schedule procedures.

2. The Ambulatory Surgery Unit will operate on Tuesday and Thursday of each week from 0730-1630 hours.

3. Scheduling will be on a first-come, first-served basis.

4. The number of cases each day will be limited to four or five unless special arrangements are made with the head nurse of the unit and the anesthesiologist.

a. Each patient will be assigned a time to return on the day of surgery.

b. Every attempt will be made to assign children early in the morning with the youngest scheduled first. Arrival times then will be staggered throughout the morning in order to minimize preoperative waiting time.

5. The patient will be scheduled for a preoperative evaluation and testing in accordance with the preadmission and testing SOP.

6. In the event a patient for ambulatory surgery is cancelled or fails to arrive for his surgery, the admissions office needs to be informed of the cancellation. Call PAD at 2635.

7. When the anesthetist cancels a patient deemed unsuitable for ambulatory surgery, the referring surgeon will be informed and other arrangements made for the patient.

8. Patients who fail to arrive are called at home. If the patient cannot be reached, the referring clinic is notified of the situation and the admission is cancelled.

APPENDIX T

IMPLEMENTATION PLAN

IMPLEMENTATION PLAN

TASK	RESPONSIBLE INDIVIDUAL
1. Implement a preadmission testing program for ambulatory surgery patients.	Deputy Commander for Clinical Services
2. Appoint an Ambulatory Surgical Unit Coordinator.	Deputy Commander for Clinical Services with input from the Chief, Department of Nursing
3. Publish a lsit of recommended ambulatory surgical procedures and seek additional input from the professional staff.	Ambulatory Surgical Unit Coordinator
4. Discuss the projected impact and utilization of ambulatory surgery services at Keller.	Deputy Commander for Clinical Services/Ambulatory Surgical Unit Coordinator
5. Discuss medical record requirements with both the professional and nursing staff.	Chief, Patient Administration
6. Distribute copies of the proposed ambulatory surgery policies and procedures to each clinic and solicit input from them.	Ambulatory Surgical Unit Coordinator
7. Establish a "kick-off" date for implementing the program. Coordination should be made with the Chiefs of Anesthesiology, Department of Nursing, Patient Administration and Surgery.	Hospital Commander
8. Publish articles in the post newspaper in order to familiarize the patient population with the concept and benefits of ambulatory surgery.	Adjutant/Ambulatory Surgical Unit Coordinator
9. Discuss the concept and benefits of ambulatory surgery during community meetings, i.e., monthly Mayors' meeting and Retired Officers' Association.	Hospital Commander/Deputy Commander for Administration

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