BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Defense

Implementing Outpatient Surgery Programs In Military Hospitals Can Reduce DOD's Health Care Costs

Outpatient (or same day) surgery has received widespread attention from nonfederal health care providers as a way to reduce health care costs. GAO found that military hospitals have made limited use of outpatient surgery to reduce military health care costs.

At the six military hospitals reviewed, GAO estimates that in 1982 about 5,600, or about 65 percent, of about 8,600 inpatient surgeries that had outpatient surgery potential could have been performed on an outpatient basis. Military surgeons helped GAO make this determination. GAO believes that if these inpatient surgeries had been done on an outpatient basis, hospital beds and other resources at these six hospitals would have been available and could have been used to treat patients who had been referred to the civilian sector under the Department of Defense (DOD)-financed Civilian Health and Medical Program of the Uniformed Services.

Based on (1) the private sector's experience that outpatient surgery is a safe and cost-effective alternative to inpatient surgery for many surgical procedures and (2) GAO's findings concerning the potential for wider use of such surgery in the military services, GAO recommends that the Secretary of Defense direct the Assistant Secretary (Health Affairs) to develop a DOD-wide policy on outpatient surgery programs in military hospitals where analyses show that such programs would reduce DOD's total health care costs.

GAO/HRD-85-23
MAY 24, 1985

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-218793

The Honorable Caspar W. Weinberger
The Secretary of Defense

Dear Mr. Secretary:

This report discusses the need for a Department of Defense-wide policy on outpatient surgery programs in military hospitals.

The report contains a recommendation to you on page 21. As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being provided to the above Committees, the Senate and House Committees on Armed Services, the Office of Management and Budget, and other interested parties. Copies are also being sent to the Secretaries of the Army, Navy, and Air Force.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY
OF DEFENSE

IMPLEMENTING OUTPATIENT SURGERY PROGRAMS IN MILITARY HOSPITALS CAN REDUCE DOD'S HEALTH CARE COSTS

D I G E S T

Advances in anesthesia, more effective ancillary support services, and greater surgical expertise have led many private sector hospitals to increase the use of outpatient (or same day) surgery for procedures that, for safety and other reasons, previously required a hospital stay. Price competition and changes in health insurance reimbursement policies, as well as medical advances and patient desire for home recovery, are expected to result in expanded use of outpatient surgery in the future. Some estimates show that up to 40 percent of all surgeries can be safely carried out on an outpatient basis, thus reducing civilian health care costs for hospital stays by as much as $5 billion annually. A 1980 American Hospital Association study of 2,137 nonfederal hospitals in 134 large metropolitan areas showed outpatient surgery was available in 70 percent of the hospitals. (See p. 1.)

In reviewing the extent to which outpatient surgery was being practiced in Department of Defense (DOD) hospitals, GAO found that outpatient surgery programs have not been encouraged by medical commands. This is because the commands generally do not believe the programs offer substantial benefits to DOD's direct care system--that component of its medical care system administered by the military services. (See p. 6.)

If the procedures had been performed on an outpatient basis, hospital resources could have been used to treat a portion of the six hospitals' 5,049 referrals to the other major component of DOD's health care system--the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This program pays for a major portion of medical care costs in civilian facilities when the care is not available from a military health care facility. (See pp. 6, 11, and 59.)

Tear Sheet

To determine the potential for military commands to implement or expand outpatient surgery programs, GAO reviewed major military command policies and guidance and performed detailed reviews of patient treatments provided during 1982 at six major military hospitals--two each from the Army, Navy, and Air Force. GAO was assisted by military surgeons designated by hospital commanders or their representatives to review sampled case files and to render opinions on the suitability of sampled patients and procedures for outpatient surgery. The hospitals were judgmentally selected to represent a mix of medium-sized and large facilities. (See pp. 2 to 5.)

CHAMPUS COSTS COULD HAVE BEEN AVOIDED BY ENHANCED OUTPATIENT SURGERY PROGRAMS

Military hospitals have generally not adopted outpatient surgery as a means of reducing health care costs. GAO reviewed a random sample of 635 inpatient surgical cases from a universe of 8,593 cases with outpatient surgery potential at the six hospitals visited. From this review, GAO estimates that about 65 percent of these cases (about 5,600) could have been treated on an outpatient basis.

GAO estimates that 10,886 inpatient bed days would have been made available if these patients had been treated on an outpatient basis. Using the 1982 nationwide daily average of $328 for CHAMPUS nonemergency inpatient bed day costs, GAO estimates that CHAMPUS expenditures could have potentially been reduced by up to $3.6 million annually by establishing or expanding outpatient surgery programs and treating CHAMPUS patients at the six hospitals. (See p. 11.)

GAO believes that its estimate of potential number of patients and procedures suitable for outpatient surgery may be conservative. The listing of potential outpatient surgery procedures GAO used as criteria to select sample cases for review included fewer procedures than are (1) performed on an outpatient basis by nonfederal health care providers or (2) contained on a similar list developed for CHAMPUS. (See p. 12.)

MILITARY MEDICAL OFFICIALS' CONCERNS REGARDING OUTPATIENT SURGERY PROGRAMS SHOULD NOT PRECLUDE THEIR ADOPTION

Hospital commanders and other local command medical personnel in all three services said outpatient surgery programs either have not been implemented or have not been expanded because (1) patient population characteristics, such as age and residence distance from the hospitals, limit the potential for outpatient surgery and (2) operating room capability and facilities are not adequate to support an outpatient surgery program. GAO found that about 15 percent of the cases it reviewed were found unsuitable for outpatient surgery because of such factors as patients' ages, the distances from their homes to the hospitals, or the lack of needed assistance after discharge. (See p. 14.)

In addition, all of the hospitals visited may have had operating room or other facility limitations that could limit fully developing outpatient surgery programs. All the hospitals, however, had less than full operating room utilization rates (ranging from 50 to 77 percent). And the hospitals with other facility limitations, such as limited recovery room space, had underused space that could be converted to accommodate an expanded outpatient surgery program. GAO did not assess the conversion costs at these hospitals because hospital officials had no estimates available. Individual hospital analyses would be necessary to determine whether the potential recurring savings to be derived from initiating outpatient surgery programs outweigh expected expenditures. (See p. 15.)

Hospital officials also told GAO that they had not implemented or expanded outpatient surgery programs because they believed the programs would adversely affect hospital staffing by reducing hospital inpatient bed days. Military medical command officials said that they had not formally directed or encouraged the adoption of these programs because they believed the programs did not offer substantial savings to the direct care system.

GAO agrees that increasing outpatient surgery at individual hospitals may not result in savings to the direct care system. GAO believes, however, that adopting or expanding military outpatient surgery programs offers substantial opportunities to enhance the usage of the direct care system's capabilities and thereby reduce DOD's system-wide medical care costs. This would occur largely because military hospitals should be able to accommodate some patients currently being treated in the private sector under CHAMPUS. GAO believes the absence of anticipated savings at the hospital level may act as a disincentive for hospital commanders to increase outpatient surgery.

This disincentive may result from the manner in which the two components of DOD's health care system are funded and administered. The direct care system is funded and operated by the respective military services; hospital commanders are responsible to the parent services for operating their facilities within the funding limitations established for the facilities. CHAMPUS, on the other hand, is centrally administered by the Office of the Secretary of Defense (Health Affairs); neither the services nor hospitals are accountable for CHAMPUS costs. (See p. 18.)

In view of the apparent lack of incentives for the military services to foster outpatient surgery programs, GAO believes that the Assistant Secretary of Defense (Health Affairs) should take action to require such programs where it is cost effective to do so. The Assistant Secretary, who serves as the principal advisor to the Secretary of Defense for all DOD health policies, programs, and activities, is responsible for making DOD-wide determinations regarding priorities and resources for DOD's health and medical programs. (See p. 19.)

RECOMMENDATION

GAO recommends that the Secretary of Defense direct the Assistant Secretary (Health Affairs) to develop a DOD-wide policy on outpatient surgery programs in military hospitals. The policy should

--require the development of a list of surgical procedures, similar to the lists developed by Medicare and CHAMPUS, suitable for performance on an outpatient basis in military hospitals;

--require that analyses be made on a hospital-by-hospital basis to determine whether implementing outpatient programs would be cost beneficial, taking into account the potential for reducing CHAMPUS costs; and

--require the military services to implement formal outpatient surgery programs in all military hospitals where analyses show that this would reduce DOD's total health care costs.

AGENCY COMMENTS

DOD provided official oral comments on a draft of this report. DOD agreed with GAO's recommendation that it develop a DOD-wide policy on outpatient surgery and that the policy contain a list of outpatient surgical procedures suitable for performance in military hospitals.

DOD expressed concern over the cost and complexity of conducting hospital-by-hospital analyses and said it would study the cost effectiveness of such an approach before deciding whether to follow it. GAO believes, however, that regardless of the methodology used, DOD will need to determine at the individual hospital level whether outpatient surgery programs are cost beneficial. Consequently, GAO continues to believe that the DOD policy should require implementation of outpatient surgery programs where it is demonstrated that such programs will reduce DOD's health care cost. (See p. 21.)

Contents

ILLUSTRATIONS

ABBREVIATIONS

CHAMPUS Civilian Health and Medical Program of the Uniformed Services

DOD Department of Defense

GAO General Accounting Office

CHAPTER 1

INTRODUCTION

Health care for members of the U.S. military services is provided by direct care medical facilities operated by the Army, Navy, and Air Force, supplemented by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The direct care medical facilities provide support to U.S. military forces; provide comprehensive medical care to military members; and when space, staff, and other resources are available, provide medical care to other eligible beneficiaries--dependents of active duty members, retirees, and dependents of retirees and of deceased members of the armed forces. CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents, retirees, and dependents of retirees and deceased members of the military services. Generally CHAMPUS is used when required care is not available from within the direct care system. For fiscal year 1985, the Department of Defense (DOD) requested about $9.5 billion to operate the military health care system, including about $7.4 billion for direct care, about $1.4 billion for CHAMPUS, about $512 million for construction, and about $167 million for other programs.

The medical facilities in the direct care system range from small clinics having limited medical capabilities to large medical centers having extensive medical capabilities and medical teaching programs. During fiscal year 1982--the year for which we conducted most of our analyses--the military services operated about 470 hospitals and freestanding clinics, including 59 hospitals with 75 or more operating beds. These 59 facilities combined had about 13,600 operating beds and performed over 473,000 surgical, diagnostic, and therapeutic procedures.[1] In fiscal year 1982, there were over 986,000 claims from civilian health care facilities under CHAMPUS.

Advances in anesthesia, more effective ancillary support services, and greater surgical expertise have led many private

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[1]Certain diagnostic and therapeutic "oscopy" procedures are considered to be surgical procedures if they permit detection and removal of abnormal body tissue or are performed without an incision through various body openings. Since these procedures are included on the approved outpatient procedures list for the Medicare program, they were included in the review and in this report will be referred to as surgical procedures.

sector hospitals to increase the use of outpatient surgery[2] for procedures that, for safety and other reasons, previously required a hospital stay. Price competition and changes in health insurance reimbursement policies, as well as medical advances and patient desire for home recovery, are expected to result in expanded use of outpatient surgery in the future. Some estimates show that up to 40 percent of all surgeries can be safely carried out on an outpatient basis, thus reducing civilian health care costs for hospital stays by as much as $5 billion annually. A 1980 American Hospital Association study of 2,137 nonfederal hospitals in 134 large metropolitan areas showed outpatient surgery was available in 70 percent of the hospitals.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine the potential for implementing or expanding outpatient surgery programs in military hospitals. We identified surgical procedures that can be performed on an outpatient basis and the concerns that may be contributing to military medical commanders' reluctance to establish or expand outpatient surgery programs. For a random sample of patients at six military hospitals, we collected data to determine the potential savings attainable by performing procedures carried out on these patients on an outpatient rather than an inpatient basis. We also obtained information on the number of patients referred to private sector health care facilities under CHAMPUS and determined the potential for treating these referrals in military hospitals.

Our audit was performed at the following six military hospitals: Darnall Army Community Hospital, Fort Hood, Texas; Martin Army Community Hospital, Fort Benning, Georgia; Wilford Hall United States Air Force Medical Center, Lackland Air Force Base, Texas; United States Air Force Regional Hospital, Langley Air Force Base, Virginia; Navy Regional Medical Center, Jacksonville Naval Air Station, Florida; and Portsmouth Naval Hospital, Portsmouth, Virginia. Information was also obtained from the military services regarding the universe of surgical, diagnostic, and therapeutic procedures performed in all military hospitals with 75 or more operating beds. We also reviewed literature obtained through a search of the DIALOG Health Planning and Administration

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[2]In this report, the term "outpatient surgery" refers to surgical procedures that are more complex than those performed in a clinic setting, e.g., doctor's office, but less complex than procedures that, for safety and other reasons, require at least an overnight stay in the hospital. The terms outpatient, ambulatory, and same day surgery are often used interchangeably.

Database of the U.S. National Library of Medicine to identify developments in the field of outpatient surgery in the nonfederal health care field.

Hospital selection

We judgmentally selected the six hospitals for review after consultation with the Surgical Consultant, Office of Air Force Surgeon General, Brooke Air Force Base; the Chief of Staff and other officials of the Army's Health Services Command; and the Director of Internal Review, Navy Medical Command. Hospitals were selected to represent a mix of medium-sized and large facilities. Factors considered in hospital selection included the number of operating beds, clinical specialties available, types of patients served (i.e., active duty, dependent, or retiree), and availability of outpatient surgery programs. Characteristics of the selected hospitals are discussed in appendix I.

Criteria for identifying surgical procedures appropriate for outpatient surgery

Provisions of the Omnibus Reconciliation Act of 1980 extended Medicare coverage to include the facility costs associated with surgical procedures performed in an outpatient surgery center or physician's office. These provisions also directed the Secretary of Health and Human Services, in consultation with the National Professional Standards Review Council and appropriate national medical organizations, to specify the surgical procedures that would be appropriate for coverage under the law. The list of covered procedures was published in August 1982.

For our review, we used the Secretary's published list of about 400 procedures as criteria for identifying procedures appropriate for outpatient surgery in military hospitals. The list was augmented with nine additional procedures identified by military surgeons at Darnall Army Community Hospital and at Wilford Hall United States Air Force Medical Center as being appropriate for outpatient surgery. The augmented list is presented in appendix II.

Patient sample selection

The cognizant medical commands provided computer tapes of calendar year 1982 inpatient treatment files, which contained all surgical procedures performed on patients during the year at the six hospitals reviewed. Using these tapes and the augmented list of outpatient procedures approved for Medicare, we performed a computer-assisted match to identify the universe of patients at the six hospitals during 1982 who had undergone one or more of

the procedures with outpatient surgery potential. We selected a random sample of patients from these hospital universes and performed analyses to determine whether their surgeries could have been performed on an outpatient basis. We chose calendar year 1982 for our analyses because it was the most recent year for which complete computer tapes of inpatient treatment were available.

Universes and sample sizes for the respective hospitals are discussed in appendix III.

Sample analyses

We obtained the hospital inpatient medical records for our sample patients and collected such data as the patient's age, place of residence, eligibility classification (i.e., active duty, retired, or dependent), and reason for hospital admission. For each patient we also collected data on medical diagnosis, surgical procedures performed, type of anesthesia (local, regional, or general) used in surgery, dates of hospital admission and discharge, and whether the patient was discharged to his/her home or to a barracks or ship. We provided these data to surgeons at the respective hospitals who were designated by the hospital commander, the director of hospital services, or the chief of the department of surgery. The surgeons reviewed the cases and provided medical opinions on whether (1) the surgical procedures were suitable for outpatient surgery and (2) the sample patients could have safely undergone the procedures on an outpatient basis.

When the reviewing surgeons deemed procedures or patients unsuitable for outpatient surgery, they gave reasons to support their opinions. At the Langley Air Force Base hospital, the reviewing surgeon classified 30 from a sample of 102 cases where general anesthesia was used as unsuitable because the hospital's policy required that only local or regional anesthesia could be used for outpatient surgery. GAO's medical advisor reviewed these cases and gave his opinion as to the suitability for outpatient surgery. We used this second opinion as a basis in reaching conclusions regarding procedure and patient suitability for outpatient surgery. Use of this second opinion had a minor impact on our review results. The results of our case suitability analyses are shown in appendix IV.

Potential for outpatient surgery programs to reduce CHAMPUS costs

When space or other resources for inpatient care are not available at military medical facilities, military hospitals issue certificates of nonavailability to patients so they can

obtain private sector care under CHAMPUS. At each hospital visited, we identified the number of such certificates issued in 1982 because of excessive waiting times for admission. (See app. V.) At least some of these CHAMPUS patients could potentially have been treated in the military hospitals if space were made available through the greater use of outpatient surgery. We also identified CHAMPUS expenditures incurred during 1982 for beneficiaries who resided within the geographic areas designated by military commands for service coverage by the six hospitals reviewed. Nationwide, 1982 CHAMPUS inpatient hospital expenditures totaled $671 million, $59 million of which was within the geographic areas designated by military commands for service coverage by the six hospitals in our review.

We computed the potential CHAMPUS costs that could have been avoided by treating patients who had been referred to CHAMPUS in military hospital beds made available because of outpatient surgery. In making our computation, we assumed that (1) all nonavailability statements were issued for valid reasons, (2) beds and other services would have become available to CHAMPUS beneficiaries at the times needed, and (3) savings would have been equivalent to the nationwide average daily CHAMPUS nonemergency inpatient bed day cost during 1982. To the extent beds would not have become available at the appropriate times or in the appropriate specialties as needed, CHAMPUS patients could not have been used to fill excess beds created by an outpatient surgery program. We could not ascertain the frequency with which an exact matching would have occurred.

Applicability of sample results to other hospitals

The results of our review are representative only of the six hospitals we visited. However, analyses of the types and numbers of surgical, diagnostic, and therapeutic procedures performed in 35 military hospitals with 75 or more operating beds indicate that procedures similar to those in our review are frequently being performed in other military hospitals on an inpatient basis.

We initiated our field survey and analyses at Darnall Army Community Hospital, Fort Hood, Texas, in June 1983; expanded the review to five additional hospitals beginning in September 1983; and completed our data gathering and analyses in February 1984.

We discussed the results of our work with officials at each hospital visited and with the cognizant medical commands.

Our review was performed in accordance with generally accepted government audit standards.

CHAPTER 2

POTENTIAL SAVINGS AVAILABLE BY INCREASING USE OF OUTPATIENT SURGERY

Outpatient surgery has received recent widespread attention from nonfederal health care providers as a means to reduce health care costs without reducing the quality of care. The military can also adopt or increase the practice of outpatient surgery for selected surgical procedures in its direct care facilities. This could reduce costs for these procedures and also free up resources so the hospitals could treat at least some of those patients currently referred to private hospitals under CHAMPUS. As discussed in chapter 3, however, outpatient surgery programs have not been encouraged by medical commands because they generally do not believe the programs offer substantial benefits to the direct care system. Command officials, however, do not have empirical evidence to support this view.

During 1982 an estimated 5,600 patients at the six military hospitals we reviewed were hospitalized for surgical procedures that could have been done on an outpatient basis. If the procedures had been performed on an outpatient basis, hospital resources could have been used to treat a portion of the six hospitals' 5,049 CHAMPUS referrals, resulting in a savings to CHAMPUS of up to $3.6 million.[1]

OUTPATIENT SURGERY WITHIN THE PRIVATE SECTOR, AN EXTENSIVE AND EXPANDING PRACTICE

Private and federal insurance programs are revising reimbursement policies to encourage nonfederal health care providers to expand the practice of outpatient surgery and reduce health care costs. The Department of Health and Human Services estimates that, nationwide, $5 billion can be saved annually if 40 percent of the 20 million surgical procedures performed each year are done on an outpatient basis. In addition to saving money, outpatient surgery (1) enables hospitals to use facilities and equipment more effectively and (2) allows patients to recover at home and thus avoid emotional stresses associated with hospitalization.

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[1]This estimate has a sampling error of $0.4 million at the 95-percent confidence level. (See app. VIII.)

Current and future use of outpatient surgery in the private sector

Private physicians perform outpatient surgery extensively in hospital-based units and independent, freestanding surgery centers throughout the United States. For example, a 1980 American Hospital Association survey of 2,955 nonfederal hospitals in the 134 largest U.S. Standard Metropolitan Statistical Areas revealed that 1,506 (70 percent) of the 2,137 responding hospitals offered outpatient surgery. The survey also reported that 54 percent of the responding hospitals that offer outpatient surgery have organized programs and that the likelihood of a hospital's having an organized program tends to increase as a hospital's bed capacity increases. Of the 1,506 responding hospitals offering outpatient surgery, 87 percent said they use their main surgical suites for both inpatient and outpatient surgery.

Outpatient surgery is also performed in freestanding surgery facilities that are separate from other general health care facilities. According to the American Medical Association, in 1982, 175 freestanding facilities contracted with the various Blue Cross/Blue Shield Associations to perform outpatient surgery. Furthermore, CHAMPUS has authorized 169 accredited freestanding outpatient surgery centers to perform outpatient surgery on its beneficiaries.

According to a January 1983 American Health Consultants Inc. publication, outpatient surgery is expected to increase in the future. The director of the American Hospital Association's Division of Ambulatory Care expects hospitals that already have outpatient surgery programs to expand their services and foresees expanding use of outpatient surgery because of increased emphasis on price competition in the health care industry. The executive director of the American Academy of Medical Administrators believes pressure from the government and insurance companies will significantly increase outpatient surgery in hospitals.

Types of outpatient surgery facilities in the private sector

Many terms have been used to describe the outpatient surgery units that have been established thus far. The three basic models used in the private sector are (1) the hospital-based, nondedicated unit, where the patients never occupy a private or ward hospital bed, but stay in a recovery room until their condition warrants discharge; (2) the hospital-based dedicated unit, where the hospital has separate outpatient facilities

within the hospital to which patients are admitted and discharged; and (3) the freestanding unit, which is an outpatient facility physically separate from other health care facilities.

Hospital-based units, both nondedicated and dedicated, require little additional capital investment and are the most commonly used units. These units use existing staff, facilities, and support services to provide flexibility and to permit experimentation with outpatient surgery without substantial additional expense. If complications arise during outpatient surgeries, such units enable surgeons to do major procedures without transferring the patient to other facilities. One disadvantage of such units is that they may subject outpatients to as much administrative detail as inpatients.

Because freestanding units provide separate registration, preoperative procedures, operating rooms, and postoperative areas, the units make patient care easier and more convenient. Disadvantages associated with freestanding facilities include high capital financing costs and the potential inability to deal quickly with complications resulting from lack of quick access to more sophisticated hospital services should this become necessary.

Types of outpatient surgery procedures in the private sector

The outpatient surgical procedures performed in the private sector are ones that may be more complex than those carried out in physicians' offices, but not as complex as those requiring prolonged postoperative monitoring and hospital care to ensure patient safety. According to a 1980 American Hospital Association survey, the 1,506 nonfederal hospitals that offered outpatient surgery performed 18 percent of their annual surgical procedures on an outpatient basis. The survey also showed that in 1979 outpatient surgery accounted for 8 percent of total surgical revenue.

The following table shows the 10 procedures performed most often in freestanding facilities, as identified by a 1980 Freestanding Ambulatory Surgical Association study. The study reported that these 10 procedures account for over 70 percent of all procedures performed annually in freestanding outpatient surgery centers.

Most Frequently Performed
Outpatient Procedures During 1980

Procedure	Number	Percentage of all outpatient procedures
Dilation and curettage	13,223	17.2
Myringotomy (incision of tympanic membrane of middle ear)	10,251	13.4
Tubal ligation	7,457	9.7
Orthopedic procedures	5,895	7.7
Dental procedures	4,039	5.3
Excision of skin lesion	3,813	5.0
Diagnostic laparoscopy	2,865	3.7
Tonsillectomy and adenoidectomy	2,725	3.6
Cystoscopy	2,347	3.1
Arthroscopy	2,064	2.7
Total	54,679	71.4

Increasing impetus from private insurance companies and government is expected to increase the number of surgical procedures performed on an outpatient basis. Private insurers have already begun to limit payment for certain procedures to the cost of performing them on an outpatient basis. Both Medicare and CHAMPUS have begun to encourage providers to perform outpatient surgery by reducing payment restrictions on facility services, physicians' fees, and beneficiary copayments. For example, Medicare regulations were revised effective September 7, 1982, to permit payment for approved outpatient surgical procedures performed in non-hospital-affiliated outpatient surgery centers.[2] The regulations eliminate deductible and coinsurance amounts for facility service costs and physicians' fees, provided physicians agree to participate in the Medicare program, for about 400 procedures considered suitable for outpatient surgery.

CHAMPUS has drafted revised reimbursement policies that will permit active duty dependent beneficiaries to limit their cost for specified outpatient surgical procedures to $25, rather than their previous cost share of 20 percent of allowed charges

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[2]Outpatient surgery and other outpatient services in a hospital or in a hospital-affiliated ambulatory surgical center are reimbursed under Part B of Medicare at 80 percent of the reasonable cost.

after satisfying the deductible. These policies will permit payment for surgical procedures performed in approved outpatient surgical units, both freestanding and hospital based, and designate about 800 procedures that CHAMPUS believes can be performed safely in an outpatient setting. The CHAMPUS list of approved procedures is more comprehensive than the Medicare list because it contains procedures that are applicable to a wider patient population than that served by Medicare.

OUTPATIENT SURGERY IS NOT A WIDESPREAD PRACTICE AMONG MILITARY HOSPITALS

Commanders of individual hospitals or chiefs of surgical services decide the extent to which outpatient surgical services may be performed in their hospitals. The surgical consultant, Office of Air Force Surgeon General, Brooke Air Force Base; the chief of staff and other Army Health Service Command officials; and the head of the Direct Care Systems Branch, Division of Health Care Operations, Office of the Chief of Naval Operations, told us that, although formal outpatient surgery programs have been established at five military hospitals, and some other military hospitals offer limited outpatient surgery, the practice is not widespread among military hospitals. The five hospitals known to have formal outpatient surgery programs are Darnall Army Community Hospital, Fort Hood, Texas; Walter Reed Army Medical Center, Washington, D.C.; Naval Hospital, Bethesda, Maryland; Malcom Grow United States Air Force Medical Center, Andrews Air Force Base, Maryland; and Wilford Hall United States Air Force Medical Center, Lackland Air Force Base, Texas. Other military hospitals may also be performing some outpatient surgery, but have no formal programs.

Among the six hospitals involved in our review, two--Darnall and Wilford Hall--have formal programs and separate, dedicated outpatient surgery facilities. Langley Air Force Base Hospital also has an outpatient surgery program, but its program is limited by a hospital policy that precludes performing outpatient surgery on any patient requiring general anesthesia. At the other three hospitals visited, officials have promulgated no formal programs or guidance for such surgery although some outpatient surgeries are being performed.

The six hospitals we visited were not fully realizing opportunities for performing outpatient surgery. For example, although Darnall Army Community Hospital has had two dedicated outpatient surgery operating rooms since October 1982, during the 9-month period ended June 1983, one room was used 32.6 percent of the available time, while the other was not used at all. At Wilford Hall United States Air Force Medical Center, which established an outpatient surgery facility in March 1983,

three of the four dedicated operating rooms were used for surgery 17.4 percent of the available time for the 5.5-month period ended August 31, 1983. The fourth room was used for electroshock therapy. At these two hospitals, operating room supervisors cited a lack of sufficient operating room staff as the cause for low utilization rates. We noted, however, that while the dedicated facilities were underutilized, physicians were performing outpatient surgery procedures in the hospitals' regular operating rooms and treating these patients on an inpatient basis.

POTENTIAL AVOIDANCE OF CHAMPUS COSTS FROM OUTPATIENT SURGERY AT SIX HOSPITALS VISITED

In reviewing a sample of 635 inpatient surgical cases from a universe of 8,593 cases with outpatient surgery potential at the six hospitals visited, we found that 64.9 percent could have been treated on an outpatient basis. (See app. VI.) The 8,593 patients were hospitalized for an estimated 16,688 days during 1982. (See app. VII.) We estimate that a maximum of 10,886 additional bed days would have been available to treat CHAMPUS patients if surgical procedures performed on patients at the six hospitals we reviewed had been performed on an outpatient basis. Using the 1982 nationwide daily average of $328 for CHAMPUS nonemergency inpatient bed day costs, we estimate that CHAMPUS expenditures could have potentially been reduced by up to $3.6 million annually (10,886 days at $328 per day) by establishing or expanding outpatient surgery programs and treating CHAMPUS patients at the six hospitals. (See app. VIII.)

If the patients who received care in military facilities had been treated on an outpatient basis, hospital resources and support services used to treat them as inpatients could have been used to treat a portion of the 5,049 patients referred by the hospitals to CHAMPUS during 1982 because of excessive waiting times to get care. (See app. V.)

In deriving our estimate of up to $3.6 million potential savings from increasing outpatient surgery, we noted that the hospitals we reviewed did not appear to have significant unused operating bed capacity. Military hospitals with existing significant unused capacity might not be inclined to start or expand outpatient surgery programs because such surgery would eventually lead to a decrease in the need for inpatient operating beds unless those beds were to become occupied by patients who might otherwise be referred to CHAMPUS for treatment.

During fiscal year 1982 the six hospitals at which we made our review had, based on their average daily patient load in

operating beds,[3] an overall occupancy rate of 89.5 percent. Individual hospital occupancy rates ranged from 72.0 percent at Langley, the smallest hospital visted, to 93.8 percent at Wilford Hall, the largest. (See app. I.) A senior health facility planner in the Office of the Assistant Secretary of Defense (Health Affairs) advised us that hospitals with occupancy rates of 80 to 85 percent are generally considered fully occupied. Such hospitals normally cannot fill all beds due to limitations including (1) the inability to mix male and female or children and adult patients, (2) the need to isolate patients with infectious diseases, and (3) the need to place some patients in specific specialty care units, such as pediatrics or obstetrics.

Our estimate assumed that all CHAMPUS certificates of nonavailability of care in military facilities were issued for valid reasons. We further assumed that at least some bed days would become available to recapture CHAMPUS workload. The number of bed days we assumed was the lesser of

--the estimated number of bed days that could have been available had the procedures been performed on an outpatient surgery basis or

--the estimated number of bed days used in civilian hospitals by CHAMPUS referrals from the six hospitals reviewed. (See app. VIII.)

We believe our estimate of potential numbers of patients and procedures suitable for outpatient surgery is conservative because the list of about 400 procedures approved for the Medicare program that we used to select patient samples includes fewer procedures than are (1) performed on an outpatient basis by nonfederal health care providers and (2) contained on a similar list developed for CHAMPUS.

A list of outpatient surgical procedures developed by CHAMPUS contains about 800 procedures. Because CHAMPUS uses a different coding system than that used by Medicare--procedures are broken down into subgroups--the CHAMPUS list should not be viewed as containing twice as many procedures as the Medicare list. However, we were informed by the policy specialist, Office of CHAMPUS, that the CHAMPUS list includes procedures from the Medicare list, as well as lists prepared by, among others, the Blue Cross Association and the Blue Cross/Blue Shield Association of California.

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[3]Operating beds are defined as beds that are available for occupancy, i.e., staff is available.

We did not offset our estimate of CHAMPUS cost avoidances by one-time facility modifications that may be necessary at the Langley, Portsmouth, or Jacksonville locations. (See p. 17.) Officials at these facilities believe they would need additional funding to implement an outpatient surgery program, but could not provide precise estimates of the amounts.

CHAPTER 3

MILITARY MEDICAL OFFICIALS' CONCERNS REGARDING OUTPATIENT SURGERY PROGRAMS SHOULD NOT PRECLUDE THEIR ADOPTION

Hospital commanders and medical personnel from all three services said that (1) patient population characteristics could limit outpatient surgery potential and (2) some hospitals have insufficient operating room capability and inadequate facilities to support an outpatient surgery program.

We found that, although some patients may not be candidates for outpatient surgery because of distance from home or lack of needed assistance after discharge, these factors affected a small percentage of patients at the hospitals we reviewed. Our analyses showed that hospitals generally have adequate operating room capability but face some other potential facility limitations that can hamper efforts to implement or expand outpatient surgery programs. Where facilities are not adequate, hospital commanders should be required to determine whether the potential recurring avoidance of CHAMPUS costs occasioned by an outpatient surgery program justifies the one-time costs to start or expand such a program.

Military medical command officials told us they have not formally directed or encouraged the adoption of outpatient surgery programs. Many believed that such programs did not offer substantial savings to the direct care system but could not provide evidence to support this view.

The manner in which funds for the direct care system and CHAMPUS are administered--CHAMPUS costs are not included in hospitals' budgets and hospital commanders are not accountable for them--may act as a disincentive to establish outpatient surgery programs.

CHARACTERISTICS PRECLUDING OUTPATIENT SURGERY ARE NOT GENERALLY PREVALENT AMONG PATIENTS IN MILITARY HOSPITALS

Hospital commanders and chiefs of services and clinics at the reviewed hospitals told us that outpatient surgery programs would be limited in military hospitals because many patients (1) are too young or too old for outpatient surgery, (2) must travel long distances for health care, or (3) lacked assistance after discharge (that is, they reside in barracks or on ships). Our analyses showed that, although these and other characteristics

would limit some of these patients' potential as candidates for outpatient surgery, a significant number of patients within the population treated at military hospitals do not have these characteristics and, thus, consideration should be given to implementing or expanding outpatient surgery programs. Our analyses showed that 96 patients, or about 15 percent of the cases we reviewed, were found to be unsuitable candidates for outpatient surgery because of characteristics such as those noted above. (See app. VI.)

Several reasons (in some instances more than one for the same patient) were given for why the patients were unsuitable for outpatient surgery, as discussed below. Of the reasons given

--patient age was a contributing factor for patient unsuitability 12.6 percent of the time,

--distance from the patients' homes to the hospital was cited 17.5 percent of the time, and

--patients' inability to care for themselves after discharge was cited about 25 percent of the time. (See app. IX.)

OPERATING ROOMS AND FACILITIES GENERALLY ADEQUATE FOR OUTPATIENT SURGERY

Hospital commanders, chiefs of services and clinics, anesthesiologists, and operating and recovery room personnel at the six hospitals cited insufficient operating room capability and inadequate facilities as reasons for their not implementing or expanding outpatient surgery programs. Our analyses showed that the six hospitals generally had sufficient operating room capability both to implement outpatient surgery programs and to increase patient workloads by assuming care for current CHAMPUS referrals. Officials at three hospitals we visited cited the need for facility modifications to implement outpatient surgery programs but could not provide precise estimates on the cost of such modifications. Where facilities are not adequate, hospital commanders should determine whether the potential benefits of an outpatient surgery program justify the one-time costs to start such a program.

Hospitals have sufficient operating room capability for outpatient surgery

Analyses of the hospitals' operating room logs for April 1982--a month operating room personnel considered average as to operating room usage at the six hospitals reviewed--showed

that these hospitals used their operating rooms from 50.3 to 77.2 percent of scheduled operating room hours. The following table illustrates operating room utilization rates at the six hospitals during April 1982.

Operating Room Utilization
At Six Hospitals Reviewed
April 1982

Location	Number of operating rooms	Scheduled operating hours		Percent of utilization
		Available	Used	
Fort Hood[a]	5	880.00	595.35	67.8
Fort Benning[b]	5	907.50	469.82	51.8
Lackland[c]	14	2,464.00	1,902.47	77.2
Langley	3	528.00	265.70	50.3
Portsmouth	12	2,112.00	1,169.63	55.4
Jacksonville[d]	5	797.50	452.53	56.7
Total	44	7,689.00	4,855.50	63.1

[a]Does not include two dedicated outpatient surgery rooms. For the 9-month period ended June 1983, one of the outpatient surgery rooms was used 32.6 percent of the total available operating hours, while the second was not used.

[b]Fort Benning had eight operating rooms available but used only five to perform surgery. Two operating rooms were used for storage, and one was used as a patient preparation room.

[c]Does not include four dedicated outpatient surgery rooms. For the 5.5-month period ended August 1983, three of the dedicated rooms were used 17.4 percent of the available operating hours to perform surgery, and the fourth was used for electro-shock therapy.

[d]Jacksonville had six operating rooms, but one had specialized equipment and was not suitable for general surgical procedures.

As shown, each hospital reviewed had operating room capacity to perform additional surgeries, outpatient or otherwise, during scheduled operating hours.

Three hospitals may need facility modifications to implement or expand outpatient surgery

The operating room supervisors at the U.S. Naval Hospital, Portsmouth, and the Air Force Regional Hospital, Langley, told us that their recovery rooms have inadequate space to permit implementation or expansion of outpatient surgery programs. At the Naval Regional Medical Center, Jacksonville, the commander told us that he would be unable to expand his patient workload because of clinic space limitations. We did not assess the cost of converting underutilized space to meet the needs of outpatient surgery programs at the three hospitals because no precise cost estimates were available. We believe, however, that the three hospitals can use our estimate of the annual savings potential from implementing an outpatient surgery program to assist in their decisions concerning whether to make necessary facility modifications to support outpatient surgery programs. The other three hospitals visited did not cite inadequate facilities as reasons for not implementing or expanding outpatient surgery programs.

At the U.S. Naval Hospital, Portsmouth, the operating room supervisor told us that a ward area to accommodate 40 to 50 patients was requested to be made available for an outpatient surgery admission, preparation, recovery, and discharge area. The commander stated that the hospital budget did not include sufficient funding to convert a ward.

The Air Force Regional Hospital, Langley, uses an eight-bed recovery room to support both inpatient and outpatient surgery. The hospital anesthesiologist, the operating room supervisor, the surgical ward supervisor, and surgeons in two clinics told us that this recovery room is inadequate to support an expanded outpatient surgery program. At the time of our review, Langley was performing outpatient surgeries only on patients under local or regional anesthesia. All general anesthesia patients, regardless of the surgical procedure performed on them, were required to be admitted for a day or more as a safety precaution. During fiscal year 1982, Langley's bed occupancy rate averaged 72 percent, and our analyses showed that 76.5 percent of a random sample of potential outpatient procedures that were performed on an inpatient basis could have been done on an outpatient basis. (See app. VI.)

The commander of the Naval Regional Medical Center, Jacksonville, told us, and we observed, that more clinic space is needed at the hospital. For example, during a hospital tour we observed that the physicians' offices and examining rooms are often combined in the clinics. We also noted that many patients

were sitting in hallways waiting to see the physicians. In addition, we observed that patient rooms on one floor were being used for a conference room, training classrooms, offices, and other functions rather than for their original purpose.

The Jacksonville Medical Center has submitted a high-priority request to higher command levels for funding to build more clinic space but had no plans to establish an outpatient surgery program.

We recognize that some costs may be incurred to implement an outpatient surgery program. We believe, however, that a determination should be made on whether the recurring savings justify the one-time start up costs that would be incurred. Where net savings are possible, we believe outpatient surgery should be implemented.

TOTAL DOD HEALTH CARE COSTS ARE NOT CONSIDERED IN DECIDING WHETHER TO IMPLEMENT OUTPATIENT SURGERY

Hospital officials and the services' medical command officials have not fully considered the impact outpatient surgery could have on their hospitals' ability to provide service to a portion of their CHAMPUS referrals. Not only could those officials not identify cost savings to the direct care system, they perceived that their budgets would be adversely affected if they implemented such programs.

Chiefs of surgical services at the four hospitals in our review that did not have formal outpatient surgery programs said they believe that hospital staffing allocations would be adversely affected if outpatient surgery programs are implemented or expanded. They told us that inpatient bed-day utilization rates are a significant factor major commands use to allocate staff resources and that empty beds would result in fewer staff resources being allocated to their hospitals. Military medical command officials told us that they have not formally directed or encouraged the adoption of outpatient surgery programs. Many believe that these programs would not offer substantial savings to the direct care system but could not provide evidence to support this view.

These concerns may be valid from the hospital commanders' perspective, and the lack of savings opportunities at individual hospitals may result in disincentives for these hospitals to initiate outpatient surgery programs. However, we believe that these programs offer substantial opportunities to reduce DOD's system-wide medical costs, largely because hospitals will be able to accommodate patients now being treated in the private sector under CHAMPUS.

The manner in which DOD's health care system is funded and administered may create a disincentive for military medical officials to establish outpatient surgery programs. This appears to result at least partially from the fact that funds for the two components of DOD's health care system are appropriated and administered separately. The direct care system is funded and operated by the respective military services, and hospital commanders are responsible to their parent services for operating their facilities within the established funding limitations. CHAMPUS, on the other hand, is centrally administered by the Office of the Assistant Secretary of Defense (Health Affairs), and neither the services nor hospitals are directly accountable for program costs.

Direct care and CHAMPUS funds can be spent only in specified ways. CHAMPUS funds are to be used to purchase care from civilian sources and cannot be transferred to the direct care system to expand in-house capability. Because of this separate funding, care rendered in the direct care system may not include the CHAMPUS perspective. For example, in a paper presented at a U.S. Army Health Services Command-sponsored tri-service performance measurement conference in October 1984, a CHAMPUS official noted that under the current system of separate budgets, a local hospital commander faced with the choice of spending $25,000 from his direct care system funds or sending the patient to CHAMPUS for a government cost of $30,000 from that program's budget is most likely to choose the CHAMPUS option.

In view of the apparent lack of incentives for the military services to foster outpatient surgery programs, we believe that the Assistant Secretary of Defense (Health Affairs) should institute action to require such programs where it is found to be cost-effective to do so. The Assistant Secretary serves as the principal assistant and advisor to the Secretary of Defense for all DOD health policies, programs, and activities. Among other duties, he is responsible for reviewing budget submissions and for making determinations regarding priorities and resources for DOD's health and medical programs.

CHAPTER 4

CONCLUSIONS, RECOMMENDATION, AND DOD COMMENTS AND OUR EVALUATION

CONCLUSIONS

Outpatient surgery programs are widely used by nonfederal health care providers as a means to reduce health care costs. The Medicare program will reimburse providers for 400 surgical procedures performed on an outpatient basis. CHAMPUS has developed a list of about 800 procedures for which it will reimburse providers when performed on an outpatient basis.

Military hospitals generally make much less use of outpatient surgery than is possible and may be foregoing opportunities to lower overall DOD health care costs. We estimate potential reductions in CHAMPUS costs of up to $3.6 million if the six hospitals we reviewed were able to recapture a portion of the patients referred to CHAMPUS.

Medical command officials do not believe that outpatient surgery programs offer significant savings to the direct care system and have not promulgated formal guidance on outpatient surgery programs. Hospital commanders said that (1) patient characteristics (such as age and distance from place of residence) would limit outpatient surgery and (2) operating room capability and facilities are not adequate to support the programs.

We found, however, that patient characteristics that could limit the potential for outpatient surgery affected a small percentage of patients at the six hospitals we visited. Moreover, while all of the hospitals visited may have operating room or other facility limitations that could limit full implementation of outpatient surgery programs, all of them had less than full operating room utilization rates.

We recognize that one-time costs may be incurred to provide adequate facilities for outpatient surgery and that individual hospital analyses will be necessary to determine whether the potential recurring savings to be derived from initiating such a program at specific hospitals outweigh expected expenditures.

Hospital and command officials also believed that enhanced military outpatient surgery programs would not offer substantial savings to the direct care system and could reduce hospitals' inpatient workload and thereby adversely affect their staffing.

Both of these assertions may be valid from the perspective of the officials responsible for operating the direct care system. We believe, however, that concerns raised by military medical officials do not adequately consider the potential for reducing system-wide costs by implementing military outpatient surgery programs. This situation is attributable, in part, to the separate manner in which the direct care and CHAMPUS components of DOD's health care system are funded and administered and the apparent lack of incentives for direct care system managers to consider the potential DOD-wide benefits of outpatient surgery. Based on (1) the private sector's experience that outpatient surgery is a safe and cost-effective alternative to inpatient surgery for many surgical procedures and (2) our findings concerning the potential for wider use of such surgery in the military services, we believe that DOD should actively promote the use of outpatient surgery programs as an integral aspect of the military health care system.

RECOMMENDATION

We recommend that the Secretary of Defense direct the Assistant Secretary (Health Affairs) to develop a DOD-wide policy on outpatient surgery programs in military hospitals. This policy should

- --require the development of a list of surgical procedures, similar to the lists developed by Medicare and CHAMPUS, suitable for performance on an outpatient basis in military hospitals;

- --require that analyses be made on a hospital-by-hospital basis to determine whether implementing outpatient surgery programs would be cost beneficial, taking into account the potential for reducing CHAMPUS costs; and

- --require the military services to implement formal outpatient surgery programs in all military hospitals where analyses show that this would reduce DOD's total health care costs.

DOD COMMENTS AND OUR EVALUATION

DOD provided official oral comments on a draft of this report. The Department agreed with our recommendation to develop a DOD-wide policy on outpatient surgery in military hospitals. DOD officials told us that such a policy would encourage such surgery and also contain a list of surgical procedures suitable for performance on an outpatient basis in military hospitals. DOD officials expressed concern over the complexity and cost of conducting hospital-by-hospital analyses and said they would

study the cost effectiveness of such an approach before deciding whether to require such analyses.

We agree that DOD should use a cost-effective approach to analyze outpatient surgery program costs and benefits. However, regardless of the methodology used, DOD will need to determine at the individual hospital level whether outpatient surgery would be cost beneficial. Consequently, we continue to believe that DOD's policy on outpatient surgery programs should require implementation of such programs where analyses show them to be beneficial in reducing total health care costs.

DOD officials also told us that failure to perform outpatient surgery should not be implied to be an indication of poor quality care and pointed out that such surgery is widespread in a clinic setting at military hospitals. Our report does not suggest that lack of outpatient surgery programs indicates poor quality of care, but does indicate the potential for more efficient use of direct care system resources by shifting some of the existing inpatient workload to an outpatient basis. We did not examine surgery being performed at military clinics.

DOD also stated that the magnitude of savings from instituting outpatient surgery programs will be reduced by facility renovation or modification costs, increased staffing needed for expanded outpatient surgical activity and inpatient care, and the availability of appropriate types of inpatient beds when needed. We agree. To the extent that any one or all of these factors apply, savings would be reduced. These factors can be assessed only through hospital-by-hospital analysis. However, we believe that expanded outpatient surgery programs have the potential to free up inpatient beds, reduce CHAMPUS costs, and produce a net reduction in system-wide DOD health care costs.

DOD officials said that our estimate of patients and procedures suitable for outpatient surgery is probably not conservative as our report states because DOD military facilities either do not perform many of the Medicare-approved procedures that we used as criteria or perform them on a limited basis. We believe that our use of the Medicare list is conservative in terms of available criteria for identifying potentially suitable procedures. Had we used the more comprehensive CHAMPUS list, which contains procedures applicable to a wider population than that served by Medicare, and probably more applicable to the military hospital patient population, we probably would have identified even more procedures at the six hospitals reviewed than we identified using the Medicare list. (See app. IV.)

DOD officials acknowledged that separate funding and administration of its direct care and CHAMPUS health care components

create a disincentive for establishing outpatient surgery programs. They stated that changes in incentives must be initiated in order for outpatient surgery programs to be wholeheartedly embraced by the military health care system. They further stated that reprogramming CHAMPUS funds into the direct care system to accommodate shifting workloads and increases in staff requirements due to outpatient surgery expansion would require congressional authorization.

Reprogramming CHAMPUS funds is one DOD option to eliminate disincentives and encourage system-wide cost reduction opportunities. The need for reprogramming, however, was beyond the scope of our review. We believe that a DOD outpatient surgery policy which requires such surgery where it is cost effective could promote system-wide cost consciousness. Such a policy would encourage hospitals to recapture CHAMPUS referrals who can occupy inpatient beds freed up by inpatient surgery reduction and outpatient surgery expansion.

CHARACTERISTICS OF MILITARY HOSPITALS VISITED

ARMY HOSPITALS

Darnall Army Community Hospital, Fort Hood, Texas

Darnall Army Community Hospital is a 245-bed hospital in central Texas at Fort Hood. Darnall serves about 178,000 eligible beneficiaries within its service area. Darnall's fiscal year 1982 operating budget was $24.3 million.

Darnall provides a wide range of clinical specialties to its patients and provides surgical services for several specialties, including obstetrics/gynecology, ophthalmology, orthopedics, and urology. Darnall's bed occupancy rate for fiscal year 1982, based on its average daily patient load in operating beds, was 92.6 percent. Darnall's operating room utilization rate during normal duty hours for its five regular operating rooms averaged 67.8 percent during April 1982, a month considered "average" for the year by operating room personnel.

Darnall began performing outpatient surgery in a dedicated center with two operating rooms in October 1982. Patients having outpatient surgery come into the hospital in the morning, have their surgery, go to recovery, and return home by the end of the day. During the 9-month period ended June 1983, Darnall used one ambulatory operating room 32.6 percent of the normal operating time. The other room was not used at all during this period.

Martin Army Community Hospital, Fort Benning, Georgia

Martin Army Community Hospital is a 480-bed hospital at Fort Benning. Martin serves a population of about 90,400 who reside within a 40-mile radius of the hospital. The fiscal year 1982 operating budget at Martin totaled $22.8 million.

Martin offers a wide range of clinical specialties to its patients. Surgical services for several specialties, such as obstetrics/gynecology, ophthalmology, orthopedics, and urology, are also available. The hospital's bed occupancy rate for fiscal year 1982, based on its average daily patient load in operating beds, was 86.3 percent. The average utilization rate during normal duty hours for the operating rooms for April 1982, considered by operating room personnel to be an average month, was 51.8 percent.

There was no formal outpatient surgery program at Martin Army Hospital.

AIR FORCE HOSPITALS

Wilford Hall United States Air Force Medical Center, Lackland Air Force Base, Texas

Wilford Hall United States Air Force Medical Center is a 1,012-bed medical center with the widest range of inpatient and outpatient services available in the Air Force. Wilford Hall is in the southern part of San Antonio, Texas, at Lackland Air Force Base. It serves primarily the San Antonio area, but patients are frequently flown in from around the world. Wilford Hall serves about 178,500 eligible beneficiaries. The facility's operating budget during fiscal year 1982 totaled $55.0 million.

Wilford Hall is a busy medical center. Its outpatient clinics serve about 75,000 people each month, and it has 14 regular operating rooms where surgery in all major specialties is performed. Wilford Hall's bed occupancy rate for fiscal year 1982, based on its average daily patient load in operating beds, was 93.8 percent. The utilization rate during normal duty hours for the regular operating rooms for April 1982, considered to be an average month by operating room personnel, was 77.2 percent.

Wilford Hall also has an outpatient surgery program. Three operating rooms are used for outpatient surgery procedures. For the 5.5-month period ended August 31, 1983, the average utilization rate during normal duty hours for these three operating rooms was 17.4 percent.

United States Air Force Regional Hospital, Langley Air Force Base, Virginia

United States Air Force Regional Hospital, Langley Air Force Base, is a 98-bed hospital in eastern Virginia at Langley Air Force Base. The hospital's primary service area includes Hampton, Virginia, and about 40 other towns in Virginia. This service area overlaps with the service areas of four other military hospitals. Langley Hospital serves over 100,000 eligible beneficiaries. The hospital's fiscal year 1982 operating costs totaled $6.0 million.

The Langley Regional Hospital offers a wide range of clinical specialties to its patients. Surgery services for several specialties, including orthopedics and obstetrics/gynecology, are also available. The hospital's bed occupancy rate for fiscal year 1982, based on its average daily patient load in operating beds, was 72.0 percent. The utilization rate during normal duty hours for the three operating rooms for April 1982, considered an average month by operating room personnel, was 50.3 percent.

In the summer of 1981, Langley Hospital began a limited outpatient surgery program, which uses Langley's regular operating rooms.

NAVY HOSPITALS

Navy Regional Medical Center, Jacksonville Naval Air Station, Florida

The Navy Regional Medical Center is a 364-bed hospital at Jacksonville Naval Air Station. The medical center serves a patient population of about 129,000 residing within a 40-mile radius of the center. The center's fiscal year 1982 operating budget totaled $19.3 million.

The medical center offers its patients a wide range of clinical specialties. Surgery services for several specialties, such as orthopedics, ophthalmology, urology, and obstetrics/gynecology, are also available. The hospital's bed occupancy rate for fiscal year 1982, based on its average daily patient load in operating beds, was 88.8 percent. The average utilization rate during normal duty hours for the operating rooms for April 1982, considered to be an average month by operating room personnel, was 56.7 percent.

The medical center did not have a formal outpatient surgery program.

United States Naval Hospital, Portsmouth, Virginia

Portsmouth Naval Hospital is a 765-bed hospital in Portsmouth, Virginia. The hospital serves a patient population of about 340,700 residing within a 40-mile radius of the hospital. The hospital's fiscal year 1982 operating budget totaled $51.9 million.

The hospital offers its patients a wide range of clinical specialties. Surgery services for several specialties, such as orthopedics, obstetrics/gynecology, ophthalmology, and urology, are also available. The hospital's bed occupancy rate for fiscal year 1982, based on its average daily patient load in operating beds, was 87.1 percent. The average utilization rate during normal duty hours for the operating rooms for April 1982, considered to be an average month by operating room personnel, was 55.4 percent.

The hospital did not have a formal outpatient surgery program.

AUGMENTED LIST OF OUTPATIENT SURGICAL PROCEDURES COVERED UNDER MEDICARE

Body system/surgical procedure		CPT-4 code[a]	ICPM code[b]
Integumentary System			
Excision, benign lesion, except skin tag, trunk, arms, or legs	0.5 to 1.0 cm	11401	5884
	1.0 to 2.0 cm	11402	5884
	2.0 to 3.0 cm	11403	5884
	3.0 to 4.0 cm	11404	5884
	over 4.0 cm	11406	5884
Excision, benign lesion, except skin tag, scalp, neck, hands, feet, genitalia	0.5 to 1.0 cm	11421	5884
	1.0 to 2.0 cm	11422	5884
	2.0 to 3.0 cm	11423	5884
	3.0 to 4.0 cm	11424	5884
	over 4.0 cm	11426	5884
Excision, other benign lesion, face, ears, eyelids, nose, lips, mucous membrane	0.5 to 1.0 cm	11441	5181
	1.0 to 2.0 cm	11442	5091
	2.0 to 3.0 cm	11443	5212
	3.0 to 4.0 cm	11444	5884
	over 4.0 cm	11446	5771
Excision, skin tags, multi-fibrocutaneous tags		11200	5884
Each additional 10 lesions		11201	5884
Fingernail, toenail removal (permanent)		11750	8186
Excision, malignant lesion, trunk, arms, or legs	up to 0.5 cm	11600	5884
	0.5 to 1.0 cm	11601	5884
	1.0 to 2.0 cm	11602	5884
	2.0 to 3.0 cm	11603	5884
	3.0 to 4.0 cm	11604	5884
	over 4.0 cm	11606	5884

[a]Physicians Current Procedural Terminology, 4th Edition.

[b]International Classification of Procedures in Medicine, Volume 1.

Body system/surgical procedure		CPT-4 code[a]	ICPM code[b]
Integumentary System Cont.			
Excision, malignant lesion, scalp, neck, hands, feet, genitalia	up to 0.5 cm	11620	5884
	0.5 to 1.0 cm	11621	5884
	1.0 to 2.0 cm	11622	5884
	2.0 to 3.0 cm	11623	5884
	3.0 to 4.0 cm	11624	5884
	over 4.0 cm	11626	5822
Excision malignant lesion, face, ears, eyelids, nose, lips	up to 0.5 cm	11640	5212
	0.5 to 1.0 cm	11641	5884
	1.0 to 2.0 cm	11642	5181
	2.0 to 3.0 cm	11643	5091
	3.0 to 4.0 cm	11644	5771
	over 4.0 cm	11646	
Breast biopsy-incisional		19101	1501
Excision of cyst, fibroadenoma, or other benign tumor, aberrant breast tissue, duct or nipple lesion, male or female, one or more lesions			
-unilateral		19120	1501
-bilateral		19121	1501
Excision of benign cyst or tumor of mandible; simple		21040	5909
Pilonidal sinus or cyst excision - simple		11770	5887
-extensive		11771	5887
Skin graft - excisional preparation		15000	5888
-pinch graft		15050	5888
-split graft, up to 100 sq. cm		15100	5888
-each additional 100 sq. cm		15101	5888
Gynecomastia excision - unilateral		19140	5869
-bilateral		19141	5869
Musculoskeletal System			
Closed or open reduction of nasal fracture			
-without manipulation		21310	5217
-with digital manipulation		21315	8201
Tenotomy, subcutaneous, single, each digit		26060	5821

APPENDIX II

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Tenotomy, flexor, single, palm, open, each	26450	5821
Tenotomy, extensor, hand or finger, single, each	26460	5821
Tenotomy, subcutaneous, closed, adductor or hamstring, (seperate procedure)		
-single	27306	5821
-multiple	27307	5821
Tenotomy, Achilles tendon, subcutaneous (separate procedure)		
-local anesthesia	27605	5831
-general anesthesia	27606	5831
Tenotomy, subcutaneous, toe - single	28010	5831
-multiple	28011	5831
Tenotomy, open, flexor;		
foot - single or multiple	28230	5831
toe - single	28232	5831
Tenotomy, open, extensor, foot or toe	28234	5831
Tenotomy or release, abductor hallucis muscle	28240	5831
Tendon sheath incision for trigger finger	26055	5820
Amputation, metacarpal, with finger or thumb (ray amputation)		5840
single, with or without interosseus transfer	26910	5841
Amputation, finger or thumb, primary or secondary, any joint or phalanx,		5840
single, including neurectomies; with direct closure	26951	5841
Amputation, metatarsal, with toe, single	28810	5845
Amputation, toe - metatarsophalangeal joint	28820	5845
-interphalangeal joint	28825	5845
Sequestrectomy for osteomyelitis or bone abscess, clavicle	23170	5780
-with suction irrigation	23171	5780

APPENDIX II

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Sequestrectomy for osteomyelitis or bone abscess, scapula	23172	5780
-with suction irrigation	23173	5780
Sequestrectomy for osteomyelitis or bone abscess, humeral head to surgical neck	23174	5780
-with suction irrigation	23175	5780
Sequestrectomy for osteomyelitis or bone abscess, shaft or distal humerus	24134	5780
-with suction irrigation	24135	5780
Sequestrectomy for osteomyelitis or bone abscess, radial head or neck	24136	5011
-with suction irrigation	24137	5011
Sequestrectomy for osteomyelitis or bone abscess, olecranon process	24138	5780
-with suction irrigation	24139	5780
Sequestrectomy for osteomyelitis or bone abscess	25145	5784
-with suction irrigation	25146	5784
Tendon sheath incision at radial styloid for deQuervain's disease	25000	5820
Treatment of closed or open fracture of malar area, including zygomatic arch and malar tripod		
-without manipulation	21350	5760
-with manipulation, towel slip technique	21355	5761
Open treatment of closed or open depressed malar fracture, including zygomatic arch and malar tripod	21360	5761
Excision, subacromial (subdeltoid) bursa	23110	5834
Excision, olecranon bursa	24105	5834

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Radical excision of bursa, synovia of wrist, or forearm tendon sheaths, extensors	25116	5834
Capsulectomy for contracture		
-metacarpophalangeal	26520	5809
-interphalangeal	26525	5809
Capsulotomy, midtarsal (Heyman type)	28264	5801
Capsulotomy for contracture, metatarsophalangeal joint	28270	5801
Capsulotomy for contracture, interphalangeal joint	28272	5801
Ganglionectomy (wrist), primary	25111	5822
Ganglionectomy, recurrent	25112	5822
Excision of Morton neuroma, single each	28080	5041
Neuroma excision cutaneous nerve	64774	5041
-digital nerve, one or both, same digit	64776	5041
-digital nerve, each additional digit	64778	5041
-hand or foot, except digital nerve	64782	5041
-hand or foot, each additional nerve except same digit	64783	5041
Ostectomy, partial excision, fifth metatarsal head	28110	5784
Ostectomy, complete excision of first metatarsal head	28111	5785
-other metatarsal head (2nd to 4th)	28112	5785
-5th metatarsal head	28113	5785
-all metatarsal heads with partial proximal phalangectomies (Clayton type procedure)	28114	5785
Repair, tendon or muscle, flexor; primary single tendon or muscle	25260	5837
-secondary, single, each tendon or muscle	25263	5837

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Repair, tendon or muscle, extensor; primary, single, each tendon or muscle	25270	5837
-secondary, single, each tendon or muscle	25272	5837
Arthroplasty, metacarpophalangeal joint; single, each	26530	5819
Flexor tendon repair or advancement, single, in "no man's land," primary, each tendon	26356	5837
Profundus tendon repair or advancement -with intact sublimis; primary	26370	5837
-secondary, with free graft	26373	5837
Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft	26390	5833
Extensor tendon repair, dorsum of hand, single, primary or secondary, without free graft, each tendon;	26410	5817
dorsum of finger single, primary or secondary; without free graft, each tendon	26418	5817
Extensor tendon repair, open, primary or secondary repair, without graft	26433	5837
Suture, primary, ruptured Achilles tendon	27650	5837
Repair, fascial defect of leg	27656	5837
Repair or suture flexor tendon of leg; primary, without free graft, single, each	27658	5837
Repair or suture extensor primary without free graft, single, each tendon of leg	27664	5837
Repair dislocated peroneal tendons without fibular osteotomy	27675	5837
Repair or suture of tendon, foot, flexor, single, primary or secondary, without free graft, each tendon	28200	5837

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon	28208	5837
Hammertoe operation - one toe,	28285	5811
-cock-up fifth toe with plastic skin closure	28286	5811
Boutonniere repair using local tissues	26426	5583
-with free graft	26428	5583
-Hallux valgus (bunion) correction by exostectomy (Silver type procedure)	28920	5782
-Keller, McBride, or Mayo type	28292	5782
-Resection of joint with implant	28293	5782
-with tendon transplants (Joplin type procedure)	28294	5782
Hallux valgus (bunion) correction		
-by phalanx osteotomy	28298	5782
-by other methods (e.g., double osteotomy)	28299	5782
Reconstruction, collateral ligament, melacarpophalangeal joint	26540	5819
-with tendon or fascial graft	26541	5819
Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	26545	5819
Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies	26952	5040
-with local advancement flaps (V-Y, hood)	26952	5040
Neurectomy		
-hamstring muscle	27315	5040
-popliteal (gastrocnemius)	27320	5040
-intrinsic musculature of foot	28030	5040
Osteotomy, clavicle, with or without internal fixation	23480	5785
-with bone graft for nonunion or malunion	23485	5783
-correction of deformity; metacarpal	26565	5785
-correction of deformity; phalanx	26567	5785

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Repair for dislocating peroneal tendons without fibular osteotomy	27676	5785
Osteotomy		
-tibia	27705	5785
-fibula	27707	5785
-tibia & fibula	27709	5785
Hallux valgus (bunion) correction by double osteotomy	28299	5785
Osteotomy		
-talus	28302	5785
-metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal	28306	5782
-other than first metatarsal	28308	5782
-for shortening, angular or rotational correction; proximal phalanx, first toe	28310	5782
-other phalanges, any toe	28312	5782
Arthrotomy for synovectomy; glenohumeral joint	23105	5805
Arthrotomy for synovectomy; acromioclavicular, sternoclavicular joint	23106	5805
Arthrotomy, elbow, for synovectomy	24102	5805
Arthrotomy, wrist joint; for synovectomy	25105	5805
Radical excision of bursa, synovia of wrist, or forearm tendon sheaths; flexors	25115	5834
Synovectomy		
-extensor tendon sheath, wrist, single compartment	25118	5833
-with resection of 25 distal ulna	25119	5805
-carpometacarpal joint	26130	5805
-metacarpophalangeal joint, including intrinsic release and extensor hood reconstruction, each digit	26135	5805
-proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint	26140	5805
-tendon sheath, radical, flexor, palm or finger, single, each digit	26145	5833

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Arthrotomy		
-ankle	27625	5805
-including tenosynovectomy	27626	5805
-intertarsal or tarsometatarsal joint, each	28070	5805
-metatarsophalangeal joint, each	28072	5805
-tendon sheath; flexor	28086	5833
-tendon sheath; extensor	28088	5833
Excision of lesion of tendon or fibrous sheath or capsule;		
-foot	28090	5783
-toe	28092	5783
Arthroscopy, knee (separate procedure)	27375	1697
-with synovial biopsy	27376	1504
-with removal of loose body	27377	5800
-with partial meniscectomy	27378	5804
Fasciotomy, lateral or medial	24350	5830/5833
-with extensor origin detachment	24351	5830/5833
-with annular ligament resection	24352	5830/5833
-with stripping	24354	5830/5833
Decompression fasciotomy, flexor and/or extensor compartment	25020	5830/5833
-with debridement of nonviable muscle and/or nerve	25023	5830/5833
Fasciotomy, palmar		
-Dupuytren's contracture; closed	26040	5830/5833
-open, partial	26045	5830/5833
Fasciectomy, palmar, simple for Dupuytren's contracture; partial excision	26120	5833
-up to 1/2 palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement	26122	5830/5833
Fasciectomy, palmar, complicated, requiring skin grafting of each finger joint release	26128	5830/5833

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Fasciotomy		
-iliotibial (tenotomy), open	27305	5831
-plantar and/or toe, subcutaneous	28008	5830/5833
Arthrodesis,		
-fusion in opposition, thumb, with autogenous graft	26820	5810
-carpometacarpal joint, thumb, with or without internal fixation	26841	5812
--with autogenous graft	26842	5812
Arthrodesis,		
-carpometacarpal joint, digits, other than thumb	26843	5812
--with autogenous graft	26844	5812
-metacarpophalangeal joint, with or without internal fixation	26850	5812
--with autogenous graft	26852	5812
-interphalangeal joint, with or without internal fixation	26860	5812
--each additional interphalangeal joint	26861	5812
--with autogenous graft	26862	5812
-great toe, metatarsophalangeal joint	28750	5811
--interphalangeal joint	28755	5811
-great toe, interphalangeal joint with extensor hallucis longus transfer to first metatarsal neck	28760	5811
Arthroplasty		
-radial head	24365	5819
-with implant	24366	5819
-metacarpophalangeal joint; single, each	26530	5817
-interphalangeal joint with prosthetic implant, single, each	26536	5817
Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single	24320	5837
Repair, tendon or muscle, flexor; secondary, with free graft, each tendon or muscle	25265	5837
-extensor, secondary, with tendon graft, each tendon	25274	5837

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Tendon transplantation or transfer, flexor or extensor, single, each tendon	25310	5837
-with tendon graft, each tendon	25312	5837
Flexor tendon repair or advancement, single, not in "no man's land," secondary with free graft, each tendon	26352	5837
Flexor tendon repair or advancement, single, in "no man's land," secondary with free graft, each tendon	26358	5837
Profundus tendon repair, or advancement, with intact sublimis secondary with free graft	26372	5837
Remove tube or rod and insert tendon graft	26392	5837
Extensor tendon repair, single, primary, or secondary		
-with graft, dorsum of hand	26412	5827
-with graft, dorsum of finger	26420	5827
-with graft, central slip repair	26428	5837
-distal insertion, closed, splinting, with or without percutaneous pinning	26432	5837
-open, primary or secondary repair with free graft	26434	5837
Tendon transfer/transplant, carpometacarpal area or dorsum of hand, single, without free graft	26480	5837
-with free tendon graft	26483	5836
-palmar single, each tendon; without free graft	26485	5825
-palmar single, each tendon with free graft	26489	5825
Suture, primary, ruptured Achilles tendon		
-with graft	27652	5835
-secondary, with or without graft	27654	5835
Repair or suture of flexor tendon of leg, secondary, with or without free graft, single tendon, each	27659	5837

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Musculoskeletal System Cont.		
Repair or suture of extensor tendon of leg, secondary with or without free graft, single tendon, each	27665	5837
Repair for dislocating peroneal tendons without fibular osteotomy	27676	5837
Repair or suture foot flexor tendon, secondary, with free graft, each tendon	28202	5837
Repair or suture foot extensor tendon, secondary, with free graft, each tendon	28210	5837
Respiratory System		
Bronchoscopy		
-diagnostic rigid bronchoscope	31620	1620
-diagnostic fiberoptic bronchoscope (flexible)	31621	1620
-with biopsy, rigid bronchoscope	31625	1432
-with biopsy, fiberoptic bronchoscope (flexible)	31626	1432
-with brushing, fiberoptic bronchoscope (flexible)	31627	1432
-with tracheal or bronchial dilation or closed reduction of fracture	31630	5339
-with removal of foreign body	31635	8107
-with excision of tumor	31640	5322
-with therapeutic aspiration of tracheobronchial tree		
--initial	31645	8156
--subsequent	31646	8156
-with drainage of lung abscess or cavity		
--initial	31650	5331
--subsequent	31651	5331
-with injection of contrast material for segmental bronchography (fiberscope only)	31656	1620
-with other bronschoscopic procedures	31659	1620
Excision turbinate, partial or complete	30130	5225
Laryngoscopy, indirect (separate procedure); diagnostic	31505	1611
-with biopsy	31510	1420
-with removal of foreign body	31511	8105
-with removal of lesion	31512	5300

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Respiratory System Cont.		
Laryngoscopy direct; for aspiration	31515	1612
-diagnostic, newborn	31520	1610
-diagnostic, except newborn	31525	1610
-diagnostic, with operating microscope	31526	1610
-operative, with foreign body removal	31530	8105
--with operating microscope	31531	8105
-operative, with biopsy	31535	1420
--with operating microscope	31536	1420
-operative, with excision of tumor and/or stripping of vocal cords or epiglottis	31540	5302
--with operating microscope	31541	5302
-operative, with arytenoidectomy	31560	5302
--with operating microscope	31561	5302
-with injection into vocal cord, therapeutic	31570	5310
--with operating microscope	31571	5310
Excision, nasal polyps, extensive, requiring hospitalization	30115	5212
Sinusotomy, maxillary (antrotomy) internasal		
-unilateral	31020	5221
-bilateral	31021	5221
-radical, unilateral (Caldwell-Luc)	31030	5222
-radical, bilateral (Caldwell-Luc)	31031	5222
Ethmoidectomy, intranasal, anterior	31200	5225
-intranasal, total	31201	5225
-extranasal, total	31205	5225
Reconstruction, functional, internal nose (septal or other internasal dermatoplasty)	30620	5217
Repair nasal septal perforations	30630	5217
Submucous resection turbinate, partial or complete	30140	5214
Submucous resection nasal septum, classic	30500	5214
Cardiovascular System		
Temporal artery, ligation or biopsy	37609	5387

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Cardiovascular System Cont.		
Ligation and division of long saphenous vein at saphenofemoral junction or distal interruptions		
-unilateral	37700	5384
-bilateral	37701	5384
Ligation and division and complete stripping of long or short saphenous veins		
-unilateral	37720	5387
-bilateral	37721	5387
Ligation and division and complete stripping of long and short saphenous veins		
-unilateral	37730	5387
-bilateral	37731	5387
Ligation and division of short saphenous vein at saphenopopliteal junction		
-unilateral	37780	5387
-bilateral	37781	5387
Hemic and Lymphatic System		
Biopsy or excision of lymph node; unspecified (separate procedure)	38500	1426
-deep cervical node	38510	1426
-deep cervical node with excision scalene fat pad	38520	1426
Digestive System		
Esophagoscopy, rigid or fiberoptic (specify); diagnostic	43200	1630
-with biopsy and/or collection of specimen by brushing or washing for cytology	43202	1440
-with removal of foreign body	43215	8111
-with removal of polyp	43217	8111
-with irrigation	43218	1630
-with insertion of plastic tube or stent	43219	5428
-with dilation, direct	43220	5428

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Digestive System Cont.		
Gastroscopy, fiberoptic, without esophagoscopy; diagnostic	43700	1633
-with biopsy and/or collection of specimen by brushing or washing for cytology	43702	1441
-with removal of foreign body	43709	8112
-with removal of polyp	43711	8112
-for control of hemorrhage	43712	5608
-with fulguration of mucosal lesion	43714	1633
Dilation of rectal stricture (separate procedure) under anesthesia other than local	45910	8225
Tongue biopsy		
-anterior two-thirds	41100	1541
-posterior one-third	41105	1541
Excision branchial cleft cyst or vestige		
-confined to skin and subcutaneous tissues	42810	5291
-extending beneath subcutaneous tissues	42815	5291
Liver biopsy, percutaneous, needle	47000	1551
Vermillionectomy (lip peel), with mucosal advancement	40500	5884
Incision and drainage of ischiorectal or intramural abscess, with fislulectomy, submuscular	46060	5491
Hemorrhoidectomy, internal and external, complex or extensive, with fistulectomy, with or without fissurectomy	46262	5493
Fistulectomy; subcutaneous	46270	5496
-submuscular	46275	5496
-complex or multiple	46280	5496
Colostomy revision; simple (release of superficial scar)	44340	5464
Excision lip; transverse wedge resection	40510	5884
-V-excision with primary direct linear closure	40520	5884

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Digestive System Cont.		
Hemorrhoidectomy		
-external, complete	46250	5493
-internal & external, simple	46255	5493
--with fissurectomy	46257	5492
--with fistulectomy, with or without fissurectomy	46258	5491
Peritoneoscopy (mini-laparatomy)		
-without biopsy	49300	1694
-with biopsy	49301	1694
Repair inguinal hernia, age 5 or over		
-unilateral	49505	5530
-bilateral	49506	5532
Repair inguinal hernia, age 5 or over		
-with excision or hydrocele or spermatocele	49515	5611
-recurrent	49520	5530
-sliding	49525	5530
Repair femoral hernia, groin incision		
-unilateral	49550	5530
-bilateral	49551	5532
-recurrent, any approach	49555	5530
Repair ventral hernia (separate procedure)	49560	5535
-recurrent	49565	5535
Urinary System		
Cystourethroscopy, hospital	52100	1652
Urethral stricture dilation by passage of sound, male		
-initial	53600	5585
-subsequent	53601	5585
Urethral stricture or vesical neck dilation by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia, hospital	53605	5585
Urethral stricture dilation by passage of filiform and follower, male		
-initial	53620	5585
-subsequent	53621	5585

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Urinary System Cont.		
Dilation of female urethra, including suppository and/or instillation		
-initial	53660	5585
-subsequent	53661	5585
-in hospital, general anesthesia	53665	5585
Cystourethroscopy		
-with biopsy, hospital	52202	1562
-with fulguration (including cryosurgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands, hospital	52212	5573
-with fulguration (including cryosurgery) or treatment minor lesion (less than 0.5 cm), with or without biopsy; hospital	52222	5573
-with fulguration (including cryosurgery) and/or resection of small bladder tumor (0.5 to 2.0 cm); hospital	52232	5573
Male Genital System		
Prostate biopsy		
-needle or punch, single or multiple, any approach	55700	1463
-incisional, any approach	55705	1563
Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach		
-unilateral	54520	5622
-bilateral	54521	5623
Hydrocele excision		
-unilateral	55040	5611
-bilateral	55041	5611
Spermatocele excision, with or without epididymectomy	54840	5631
Excision of variocele or ligation of spermatic veins for variocele (separate procedure)	55530	5630

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Female Genital System		
Vulva biopsy	56600	1573
Pelvic examination under anesthesia	57410	1901
Dilation of vagina under anesthesia	57400	8228
Culdoscopy, diagnostic	57450	1696
Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	56200	5716
Vaginal tumor or cyst excision	57135	5702
Colpotomy; with exploration	57000	5701
Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	58120	5690
Laparoscopy for visualization of pelvic viscera	58980	1694
-with fulguration of ovarian or peritoneal lesions	58984	1694
-with lysis of adhesions	58985	1694
-with biopsy (single or multiple)	58986	1694
-with aspiration (single or multiple)	58987	1694
Endocrine System		
Thyroglossal duct cyst or sinus excision	60280	5066
Nervous System		
Neurolysis		
-digital, one or both, same digit	64702	5043
-nerve of hand or foot	64704	5043
-major peripheral nerve, arm or leg; other than specified	64708	5043
Neurolysis and/or transposition		
-cranial nerve (specify)	64716	5045
-median nerve at carpal tunnel	64721	5045
-ulnar nerve repair at elbow	64718	5046
-ulnar nerve at wrist	64719	5046
-ulnar nerve transfer at elbow	64718	5045

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Eye and Ocular Adnexa System		
Chalazion excision		
-single	67800	5091
-multiple, same lid	67801	5091
-multiple, different lids	67805	5091
-under general anesthesia, and/or requiring hospitalization, single or multiple	67808	5091
Discission lens (needling of lens)		
-initial	66800	5143
-subsequent	66801	5143
Foreign body removal intraocular; from anterior chamber		
-magnetic extraction	65230	5161
-nonmagnetic extraction	65235	5161
Pterygium (excision or transposition)		
-without graft	65420	5122
Plastic repair canaliculi	68700	5086
Correction everted punctum, cautery	68705	5085
Probing nasolacrimal duct, with or without irrigation, unilateral or bilateral with insertion of tube or stent (without general anesthesia)	68830	8141
Canthoplasty (reconstruction of canthus)	67950	5092
Construction intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy	67880	5095
Ectropion repair		
-suture	67914	5093
-thermocauterization	67915	5093
-blepharoplasty, excision tarsal wedge	67916	5096
-blepharoplasty, extensive (e.g., Kuhnt-Szymanowski operation)	67917	5096
Entropion repair		
-suture	67921	5093
-thermocauterization	67922	5093
-blepharoplasty, excision tarsal wedge	67923	5096
-blepharoplasty, extensive (e.g., Wheeler operation)	67924	5096

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Eye and Ocular Adnexa System Cont.		
Removal cataract		
-secondary membranous cataract ("after cataract"), with corneoscleral section, with or without irridectomy (iridocapsulotomy, iridocapsulectomy)	66830	5145
-lens material; aspiration technique, one or more stages	66840	5145
-lens material; phacofragmentation technique (mechanical or ultrasonic, e.g., phacoemulsification), with aspiration	66850	5145
Extraction lens with or without iridectomy;		
-intracapsular, with or without enzymes	66920	5144
-intracapsular, for dislocated lens	66930	5144
-extracapsular (other than 66840, 66850, 66915)	66940	5145
Insertion intraocular lens prosthesis; with cataract extraction (any technique) one stage	66980	5147
-secondary, subsequent to cataract extraction	66985	5147
Removal of Eye		
Evisceration ocular contents		
-without implant	65091	5162
-with implant	65093	5162
Enucleation eye		
-without implant	65101	5162
-with implant, muscles not attached to implant	65103	5163
-with implant, muscles attached to implant	65105	5163
Iridectomy		
-with corneoscleral or corneal section; for removal of lesion	66600	5134
-peripheral for glaucoma (separate procedure)	66625	5135
-sector for glaucoma (separate procedure)	66630	5135
-"optical" (separate procedure)	66635	5135

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
Eye and Ocular Adnexa System Cont.		
Strabismus surgery on patient not previously operated on, any procedure, any muscle		
-one muscle	67311	5101
-two muscles, one or both eyes	67312	5101
-three or more muscles, one or both eyes	67313	5101
Auditory System		
Myringotomy, including aspiration and/or eustachian tube inflation	69420	5200
Transmastoid antrotomy ("simple" mastoidectomy)	69501	5203
Myringoplasty (surgery confined to drumhead and donor area)	69620	5194
Stapes mobilization	69650	5190
Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material	69660	5191
Tympanoplasty without mastoidectomy (including canalplasty, atticotomy, and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	69631	5194
ICPM procedures and codes identified by military physicians:		
Tracheostomy (separate procedure)		5312
Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)		5635
Vasectomy		5636
Salpingotomy		5660
Total salpingectomy		
-unilateral		5661
-bilateral		5662
-removal of remaining tube		5662

Body system/surgical procedure	CPT-4 code[a]	ICPM code[b]
ICPM procedures and codes identified by military physicians: Cont.		
Bilateral endoscopic destruction or occlusion of fallopian tubes		5663
Other bilateral destruction or occulsion of fallopian tubes		5664
Surgical operations to produce male sterilization		5981

SAMPLING METHODOLOGY

This appendix describes our sampling plan and sampling errors.

From computerized patient treatment files for calendar year 1982 for six military hospitals, we identified a universe of 9,853 patient records with diagnostic and procedure codes indicating that the procedures could have been performed on an outpatient basis. The six hospitals we visited were at Fort Hood, Texas; Fort Benning, Georgia; Jacksonville, Florida; Portsmouth, Virginia; Lackland, Texas; and Langley, Virginia. We then selected a probability (statistical) sample of 740 patients from the universe. Analysis of the sample disclosed that 105 of the 740 patients should not have been in the universe or had to be eliminated for other reasons:

--In 54 cases, the procedures were coded on the patient treatment computer tapes as outpatient when, in fact, the patient records showed that the primary procedure was not outpatient.

--In 41 cases, the procedure was performed on an outpatient basis.

--In 9 cases, patient records could not be located.

--In 1 case, the patient record was incomplete.

The following table gives the original universe and sample size, the number of patients eliminated from the sample, and the adjusted sample size and adjusted universe for each hospital.

Original and Adjusted Sample Plan

Location	Universe of potential outpatient cases[a]	Sample size	Cases eliminated from sample	Adjusted sample size	Adjusted universe[b]
Fort Hood	1,320	115	8	107	1,228
Fort Benning	776	125	21	104	646
Wilford Hall	2,497	125	10	115	2,297
Langley	786	125	23	102	641
Portsmouth	2,793	125	13	112	2,503
Jacksonville	1,681	125	30	95	1,278
Total	9,853	740	105	635	8,593

[a]The universe of potential ambulatory surgery cases was extracted from Department of the Army, Navy, and Air Force patient treatment file tapes for calendar year 1982. The universe represents all cases containing surgical, diagnostic, and therapeutic procedure codes corresponding to those shown in appendix II. The universe of all surgical, diagnostic, and therapeutic cases contained in the patient treatment file tapes totaled 49,790.

[b]Adjusted universe =

$$\text{original sample universe} \times \frac{\text{original sample} - \text{cases eliminated}}{\text{original sample}}$$

We weighted the reported estimates according to the number of patients by location. For example, at Fort Hood we reviewed 107 of 1,228 patients with surgical, diagnostic, and therapeutic procedure codes that potentially could be performed on an outpatient basis. We calculated the weighting factor for Fort Hood by dividing the universe by the sample (1,228 divided by 107 = 11.48). Therefore, any observed condition involving any one of the reviewed sample cases from Fort Hood can be projected to 11.48 patients in the adjusted universe. We used the same method to calculate the weighting factor for the other five locations.

The estimates shown in our report relate only to the patients who actually underwent procedures that potentially could be performed on an outpatient basis. These estimates are representative only of the six military hospitals from which the sample cases were selected.

SAMPLING ERRORS

Because we reviewed a statistical sample of patients' records, each estimate developed from the sample has a measurable precision, or sampling error. The sampling error is the maximum amount by which the estimate obtained from a statistical sample can be expected to differ from the true universe characteristic we are estimating. Sampling errors are usually stated at a certain confidence level--in this case 95 percent. This means that the chances are 19 out of 20 that, if we reviewed the records of all patients with surgical, diagnostic, and therapeutic procedures that potentially could be performed on an outpatient basis, the results would differ from the estimates obtained from our sample by less than the sampling errors of such estimates.

At the 95-percent confidence level, our maximum sampling errors do not exceed plus or minus 9.7 percentage points for any single hospital and plus or minus 3.9 percentage points for the six hospitals combined. In other words, the chances are 19 out of 20 that (1) estimates of patient characteristics for each hospital will be within 9.7 percentage points of the corresponding true universe characteristic and (2) such estimates for all six hospitals combined will be within 3.9 percentage points of the corresponding universe characteristic. The sampling error associated with our estimate of bed days is 9.8 percent. Appendix VIII discusses the impact of that sampling error on our estimate of savings.

CASE SUITABILITY FOR OUTPATIENT SURGERY BY SURGICAL PROCEDURE CODE-- SAMPLED CASES AT SIX HOSPITALS REVIEWED

ICPM[a] procedure code	Suitable cases	Cases unsuitable due to			Total
		Procedure	Patient	Total	
1420	2				2
1432	1				1
1463	1				1
1501	11	1		1	12
1521	1				1
1541	1	1		1	2
1562	1				1
1563			1	1	1
1610	3				3
1612	2	1	2	3	5
1620	2	1	2	3	5
1630	1	1		1	2
1652	7	1		1	8
1694	29	3	3	6	35
1697	26	4	5	9	35
1901	3				3
5011		2		2	2
5040	1				1
5041	3	1		1	4
5043	15	1	1	2	17
5045	1		1	1	2
5046	1		1	1	2
5091	1				1
5096	6	1	1	2	8
5101	2				2
5122	3				3
5144	8	1	2	3	11
5145	15	2	6	8	23
5147	6		2	2	8
5148		1		1	1
5163		1		1	1
5181	1		1	1	2
5191	1				1
5194	7		2	2	9
5200	10		2	2	12
5203	1	2		2	3
5212	3	2		2	5
5217	40		7	7	47
5222	2	1	1	2	4

APPENDIX IV

ICPM[a] procedure code	Suitable cases	Cases unsuitable due to			Total
		Procedure	Patient	Total	
5300	1		1	1	2
5384		3		3	3
5491	2	3	1	4	6
5492	3	1	2	3	6
5493	2	7		7	9
5496		1		1	1
5530	49	11	27	38	87
5532	7		2	2	9
5535	6	8	2	10	16
5539			1	1	1
5541			1	1	1
5583		2		2	2
5585	9	1		1	10
5611	1	1		1	2
5622	1	2	2	4	5
5630	2	3	1	4	6
5636	1				1
5663	18	1	1	2	20
5664	11	1	1	2	13
5702	1				1
5761	1				1
5780		1		1	1
5782	13	2		2	15
5783	5	5		5	10
5784	1	6	3	9	10
5785		1		1	1
5800	3	6	2	8	11
5801	4	1		1	5
5804	5	8		8	13
5809			1	1	1
5811	1	1		1	2
5812	3	1		1	4
5817	1				1
5819	2	4		4	6
5821	2				2
5822	8	1	2	3	11
5830	1		1	1	2
5833	1				1
5835	1	1	1	2	3
5836	1	1		1	2
5837	2	3		3	5
5840			1	1	1
5860	1				1
5869	3	2		2	5
5884	17	4	1	5	22

ICPM[a] procedure code	Suitable cases	Cases unsuitable due to			Total
		Procedure	Patient	Total	
5887	4	1	1	2	6
5981	1				1
8111	2	1	1	2	4
8141	1	—	—	—	1
Total	416	123	96	219	635

[a]International Classification of Procedures in Medicine.

APPENDIX V

CERTIFICATES OF NONAVAILABILITY

ISSUED DURING CALENDAR YEAR 1982

BECAUSE OF EXCESS WAITING TIME

AT SIX HOSPITALS REVIEWED

Location	Number of certificates of nonavailability[a]
Fort Hood	202
Fort Benning	879
Lackland	61
Langley	670
Portsmouth	2,347
Jacksonville	890
Total	5,049

[a]Excludes referrals because of professional disagreement, continuity of care, personal hardship, retroactive issuance, and other. Also excludes psychiatric cases and cases for which the military hospital did not offer care in the specialty area needed.

Source: Each hospital visited.

NUMBER OF CASES DEEMED SUITABLE OR NOT SUITABLE FOR OUTPATIENT SURGERY BY SURGEONS AT SIX HOSPITALS REVIEWED

Location	Case suitability for outpatient surgery				
	Sample total	Suitable	Not suitable		
			Procedure	Patient	Total
Fort Hood	107	84	10	13	23
Fort Benning	104	62	29	13	42
Lackland	115	76	19	20	39
Langley	102	78[a]	23	1	24
Portsmouth	112	74	16	22	38
Jacksonville	95	42	26	27	53
All six hospitals	635	416[b]	123	96	219
Percentage of cases[c]	100	64.9	19.7	15.4	35.1

[a]Includes 30 cases that were deemed suitable for outpatient surgery by GAO's medical advisor.

[b]See appendix VII for estimated number of bed days associated with these cases.

[c]Occurrences weighted to reflect their proper proportion within the adjusted universe at each location.

ESTIMATED NUMBER OF CASES AND NUMBER OF BED DAYS FOR CASES WITH OUTPATIENT SURGERY POTENTIAL AT SIX HOSPITALS REVIEWED

Location	Number of outpatient cases[a]	Estimated number of cases with outpatient potential	Percent of cases with outpatient potential[b]	Average number of actual inpatient bed days spent by cases suitable for outpatient surgery	Estimated number of bed days with outpatient potential
Fort Hood	1,228	964	78.5	2.3	2,217
Fort Benning	646	385	59.6	4.7	1,810
Lackland	2,297	1,518	66.1	3.8	5,768
Langley	641	490	76.5	2.2	1,078
Portsmouth	2,503	1,653	66.1	2.8	4,628
Jacksonville	1,278	565	44.2	2.1	1,187
All six hospitals	8,593	5,576	64.9	3.0	16,688

[a]See appendix III.

[b]See appendix VI.

ESTIMATED CHAMPUS COST AVOIDANCES FROM POTENTIAL OUTPATIENT SURGERY AT SIX HOSPITALS REVIEWED

Location	Estimated number of bed days with outpatient potential[a]	Estimated number of bed days represented by CHAMPUS certificates of nonavailability[b]	Maximum bed days that could be used to recapture CHAMPUS referrals[c]	Estimated cost avoidances[d]
Fort Hood	2,217	1,677	1,677	$ 550,056
Fort Benning	1,810	7,296	1,810	593,680
Lackland	5,768	506	506	165,968
Langley	1,078	5,561	1,078	353,584
Portsmouth	4,628	19,480	4,628	1,517,984
Jacksonville	1,187	7,887	1,187	389,336
All six hospitals	16,688	41,907	10,886	$3,570,608

[a]See appendix VII.

[b]See appendix V. Computation based on certificates issued times the CHAMPUS nationwide average length of stay for nonemergency cases during fiscal year 1982 (8.3 days).

[c]See pp. 11 and 12. Represents the lesser of estimated number of bed days with outpatient potential or estimated number of bed days represented by CHAMPUS certificates of nonavailability.

[d]Based on fiscal year 1982 CHAMPUS nationwide average daily cost of hospital nonemergency inpatient care of $328 per bed day. At the 95-percent confidence level, the sampling error of the bed day estimate is 1,121 bed days for all six hospitals. The sampling error on our estimated savings is $.4 million.

APPENDIX VIII

PERCENTAGE OF CASES, CLASSIFIED BY REASON CITED FOR PATIENT'S UNSUITABILITY FOR OUTPATIENT SURGERY, AT SIX HOSPITALS REVIEWED

Reasons[a]	Percentage of reasons
Patient too old	10.5
Patient too young	2.1
Other medical or emotional problems/ complications requiring inpatient care	23.0
Patient resides too far from hospital	17.5
Patient does not have transportation available	7.7
Patient does not have self-care capability	24.5
Other	14.7
Total	100.0

[a]More than one reason was often cited by physicians as to why a patient was not considered a good candidate for outpatient surgery. This schedule includes duplicated counts.

PERCENTAGE OF CASES, CLASSIFIED BY SUITABILITY FOR OUTPATIENT SURGERY AND DISTANCE BETWEEN PATIENT RESIDENCE AND HOSPITAL, AT SIX HOSPITALS REVIEWED

Distance (miles)	Cases found suitable for outpatient surgery	Cases found not suitable for outpatient surgery	All cases with potential for outpatient surgery
Less than 20	81.7%	69.9%	77.6%
21 to 35	4.6	4.3	4.5
36 to 50	3.2	5.9	4.1
51 to 65	.5	.9	.6
Over 65	10.0	19.0	13.2
Total	100.0%	100.0%	100.0%

APPENDIX XI

PERCENTAGE OF CASES, CLASSIFIED BY SUITABILITY FOR OUTPATIENT SURGERY AND TYPE OF PATIENT RESIDENCE, AT SIX HOSPITALS REVIEWED

Patient residence	Cases found suitable for outpatient surgery	Cases found not suitable for outpatient surgery	All cases with potential for outpatient surgery
Barracks/ship	12.5%	28.4%	18.1%
Base housing	7.3	3.5	5.9
Off-base housing	80.2	68.1	76.0
Total	100.0%	100.0%	100.0%

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