

Case Log Guidelines

Review Committee for Orthopaedic Surgery

ACGME

The ACGME Case Log System for Orthopaedic Surgery allows residents to document the breadth of their surgical experience during residency and to enable the ACGME's surgical Review Committees to monitor programs to ensure that residents have an adequate volume and variety of experiences. In anticipation of the Next Accreditation System (NAS), all surgical Review Committees identified case categories that are representative of broader procedural experiences of a non-fellowship-educated surgeon in the specialty, as well as expectations for minimum numbers in each case category. The minimum number requirements represent expectations for experience—not the achievement of competence.

Effective July 1, 2013, expectations for recording CPT codes for each case changed. Residents should continue to enter all CPT codes representing their participation as Resident Surgeon for each case. However, ONE code per case must be selected as the primary code. While multiple CPT codes may apply for some cases, such as multiple levels and/or bone grafting in a lumbar decompression and fusion, a resident must choose ONE primary code to submit in the Case Log System. Additional codes should be entered to fully capture the complexity of each case and enable the Review Committee to monitor and identify trends among both the primary and secondary codes that may eventually lead to changes in the defined case categories and/or numbers.

The Review Committee recognizes that in some situations, more than one distinct surgical procedure may be performed during a single session of anesthesia. In these cases, it is appropriate for the resident to submit two separate case logs, each with its own primary code. For instance, in a case of polytrauma, there may be one procedure to fix a fractured femur, and a separate procedure to fix a fractured tibia. Two separate case logs (each with its *own* primary code) should be submitted if the resident participates in both procedures. Similarly, if bilateral procedures are done in the same setting (such as bilateral total knee arthroplasties or bilateral carpal tunnel releases), two separate cases (each with its own primary code) should be submitted in the Case Log System if the resident participates in both procedures. Following these guidelines allows equivalent tracking of the volume and variety of cases for each resident, preventing variances based on how cases are coded.

All surgical Review Committees were asked to provide guidance to programs on the level of resident participation in a case. Accordingly, the Review Committee for Orthopaedic Surgery developed the following definitions and guidelines:

Residents must log procedural experiences as either **Level 1** or **Level 2**. They should not log a procedure if they participate at less than these levels. All procedures at both levels require appropriate faculty member supervision and participation in the case. At this time, both Level 1 and Level 2 participation will count toward meeting the minimum number requirements.

Level 1 – Primary or Supervising resident surgeon: The resident is scrubbed on the case and participates in pre-operative assessment and planning. In addition:

- a. **Primary** – The resident performs key portions of the procedure.
- b. **Supervising** – The resident guides another resident through key portions of the procedure.

- NOTE: When a resident acts as a supervising surgeon and another resident is the primary surgeon, both residents may log the case as Level 1.

Level 2 – Assisting resident surgeon – The resident is scrubbed in on the case and participates in pre-operative assessment and planning, assists a more senior surgeon in the key portions, and may participate in opening or closing or other non-key portions.

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Orthopaedic Surgery Case Log Definitions

Adult Patient: Any patient 17 or older at the time of the procedure.

Pediatric Patient: Any patient younger than 17 at the time of the procedure.

Oncology Patient: Any patient for whom the procedure diagnosed or treated is primary or metastatic, benign or malignant, bone or soft tissue tumors.

Involved Microsurgery: The procedure involved a microscope in the repair of a nerve or vessel.

Primary Credit: CPT code that is used to calculate the number of cases for each of the required defined case categories. If a case is entered with more than one CPT code, one CPT code must be selected for credit. This code is the primary code. If the code selected for credit is not one of those being tracked, then while the case will count towards the total number of cases for the area/type to which it is mapped, it will not count towards the required minimum number in any defined case category.

Secondary Credit: Any CPT code that is not identified for credit. All secondary codes will count towards the total number of cases for the area/type to which it is mapped.

Trauma Cases: There are no CPT codes for trauma. The Case Log System captures trauma cases by summing the cases that include CPT codes in the “Fracture and/or Dislocation” and “Manipulation” areas of all areas except spine, integumentary, and nervous system.

Percentiles Summary Graph: Sum of all CPT codes logged for each listed area (Shoulder; Humerus/Elbow; Forearm/Wrist; Hand/Fingers; Pelvis/Hip; Femur/Knee; Leg/Ankle; Foot/Toes; Other Musculoskeletal; Spine; Integumentary; Nervous System; Miscellaneous; Oncology Cases, Microsurgeries, Trauma).

Frequently Asked Questions

Q. How were the key case categories and required minimum numbers for each identified?
[Program Requirements: IV.A.6.d).(1).(a-i)]

A. Review Committee members analyzed the national data for graduating residents for academic years 2007-2008, 2008-2009, and 2009-2010, evaluating national averages and standard deviations to develop provisional minimum required numbers. The final numbers were derived based on the collective expertise and professional judgment of the Committee members. A limited set of CPT codes were identified for each key case category. A Minimums Report is available within the ACGME Case Log System that programs can generate at any time in order to monitor resident experience in each category. While only certain CPT codes (and no more than one CPT code per case) will count towards meeting the minimum number requirements, residents should enter all CPT codes that reflect their active and meaningful participation as a surgeon, since the full Case Log Report will contain this information and may be useful at a later time for hospital credentialing requests.

Q. Are PGY-1 residents permitted to log cases in the ACGME Case Log System?
[Program Requirement: IV.A.6.e)]

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- A.** All residents **must** prospectively log cases into the ACGME Case Log System during the entirety of their residency experience. *Only orthopaedic* cases must be entered; cases completed on other services (e.g., neurological surgery) must **not** be entered. A resident completing a general surgery intern year who had not matched into an orthopaedic surgery program at the same time is not permitted to 'count' cases that may have been entered during the intern year.
- Q.** How did the Review Committee determine the minimum and maximum total numbers of required cases? [*Program Requirement: IV.A.6.e).(1)*]
- A.** The Review Committee referenced the 2008-2009 national data summarizing case totals in order to set the requirements for minimum and maximum case numbers. Based on these statistics, and utilizing the collective expertise of Committee members, the range of 1000-3000 total procedures was determined to be appropriate.
- Q.** What are the expectations for compliance with the requirement for entering resident surgical cases into the ACGME Case Log System in a timely manner?
[*Program Requirement: V.A.1).(d)*]
- A.** Cases should be entered into the ACGME Case Log System as soon as possible to ensure that the information is accurate and complete. Ideally, residents will do this daily, or at least weekly. It is suggested that the program director review the logs quarterly to make sure that resident experience is accurately reflected. Note: cases cannot be entered following completion of the program.
- Q.** How should each resident's experience in the ACGME Case Log System be monitored?
[*Program Requirement: V.A.1).(d)*]
- A.** The program director should be reviewing resident Case Log entries, and in particular the Minimums Report, at least quarterly in order to ensure that each resident is making appropriate progress towards meeting the required minimum numbers in each key case category. The program director can access this information by logging into the Case Log System with his or her ADS password and program number.
- Q.** How often does the ACGME publish Case Log data?
- A.** The ACGME publishes data for the previous academic year on the Review Committee's web page on the ACGME website no later than December 1 of each calendar year. Program personnel should contact the Executive Director of the Review Committee with any questions regarding national and program data reports. Contact information can be found on the Review Committee web page on the ACGME website.
- Q.** Can program directors view case log experience entered by residents from other programs?
- A.** No, program directors are only provided with their own program residents' data.
- Q.** What are the Review Committee's expectations for monitoring resident case logs?
[*Program Requirement V.A.2.d)*]
- A.** Programs must monitor the accurate and timely entry of cases into the system. As part of monitoring resident progress towards developing competence in surgical skills, cumulative

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operative experience reports should be generated from the Case Log System and reviewed with each resident as part of his or her semiannual review. More frequent monitoring and feedback is highly recommended.

A variety of Case Log Reports are available in the system; each providing useful information for monitoring.

- **Code Summary Report**

This report provides the number of times each CPT code is entered into the Case Log System by the program's residents. Filtering by specific CPT code, attending, institution, and/or patient type can provide useful information on surgical activity in the program that might, for example, be used to make targeted changes in rotation schedules, curriculum, faculty assignments, etc. This report can also be especially helpful in monitoring the procedures that do not count towards the minimums. Choosing non-tracked codes on the area drop-down will show the CPT codes that have been entered and will not count on the minimums report. These codes can be easily reviewed to determine if the resident miscoded something that should be adjusted or it really was a minor procedure that doesn't fit into the Review Committee minimums. Note that the Credit drop-down box defaults to "Primary." Other Credit drop-down options are "All" and "Secondary."
- **Minimums Report**

When the default settings are used, a table listing all residents in the program is generated that shows the number of cases for each resident in each defined case category, as well as the minimum number required for each. Individual tables may be generated for discussion with individual residents.
- **Resident Activity Report**

This is a summary report that provides total number of cases, total number of CPT codes, most recent procedure date and last time an update was made for each resident or for the selected resident. This report is a quick way to keep tabs on how frequently residents are entering their cases. For example, if the program requires residents to enter cases each week, the report can be run weekly; a resident that has not entered a case within the past week would be quickly identified.
- **Resident Brief Report**

The brief report lists the procedure date, case ID, CPT code, institution, resident role, attending, and description for each case for each selected resident using the selected filters. This is one of two reports that include a filter for RRC Case Type (All, Microsurgery, or Oncology).
- **Resident Experience Report by Year**

This report lists the number of procedures performed by the selected resident for each PG year as well as the total number for each area/type. The use of available filters such as resident role, patient type, area/type can provide additional insight into resident experience.
- **Resident Full Detail Report**

All information for each case entered into the Case Log System is displayed in this report, making this report most useful for getting an in-depth view of a resident's experience during a defined period. For example, this report could be generated for each resident for the preceding three-month period and used as part of a quarterly evaluation meeting with the program director or designated faculty mentor. The use of filters can be used to provide additional insight into the resident's activities (e.g., filtering for a specific defined category for a resident with a short term improvement plan that is being assessed). Note that this is the other report that includes a filter for RRC Case Type (All, Microsurgery, or Oncology).

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- Tracked Procedures for Specialty by Category
This report generates the CPT codes mapped to each defined case category as well as the CPT codes that are available but not tracked.

The use of filters allows the program to get specific information to use for targeting needed program improvements. For example, selecting a specific institution would provide data on that institution's contribution to the surgical/clinical activity in the program. If the institution was added with the goal of providing specific foot/toes procedures, the program could determine if this goal was being met. Programs are encouraged to incorporate these tools as part of their program improvement activities.