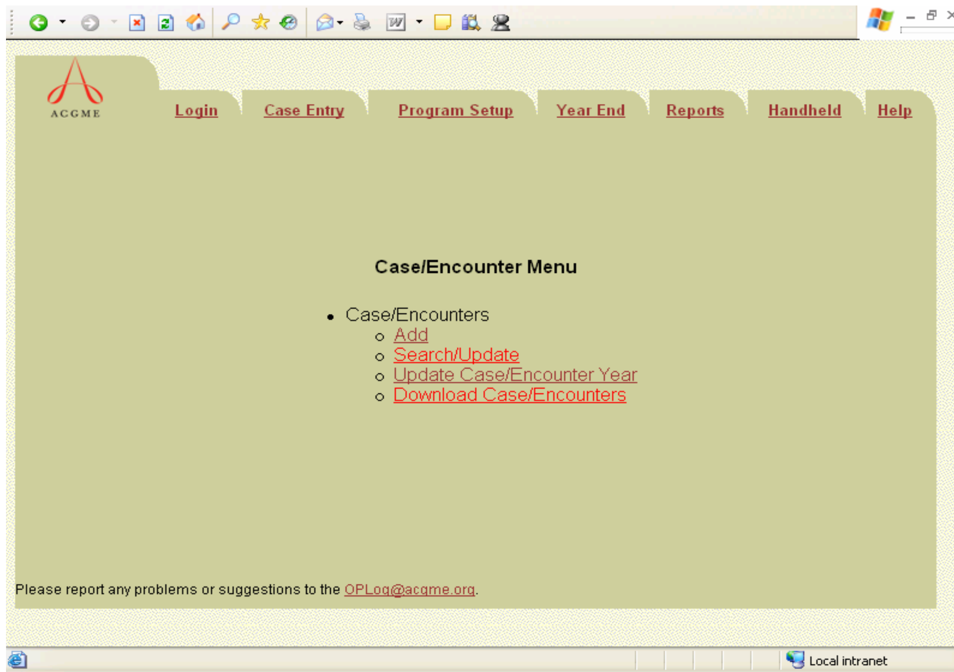
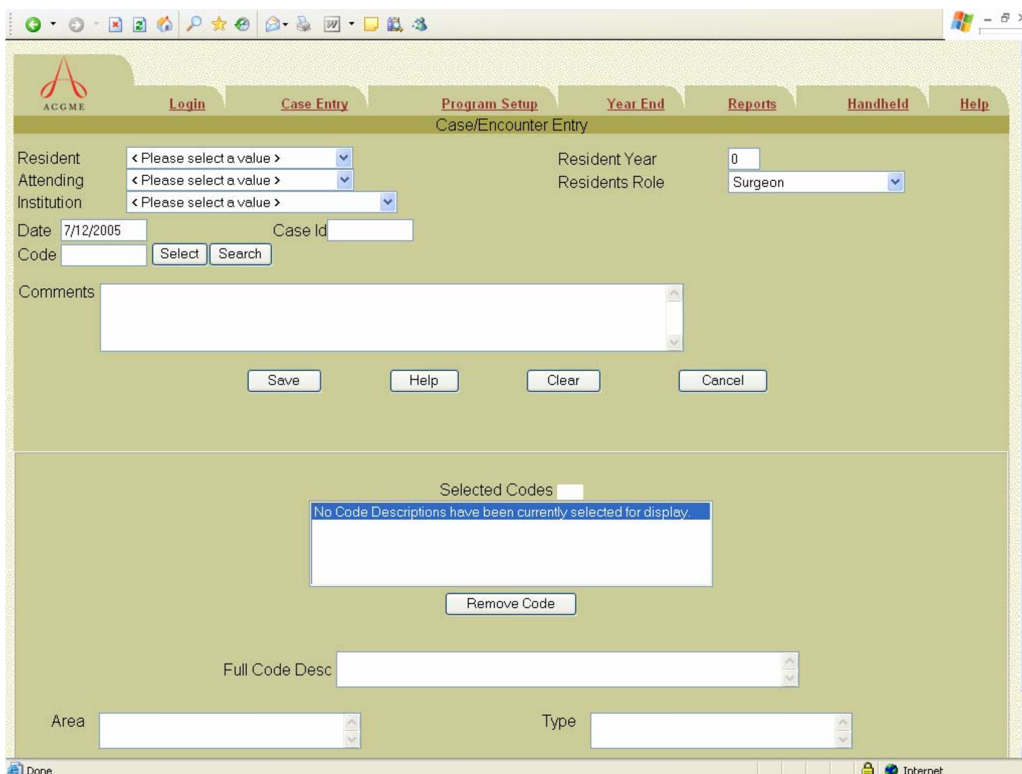
CASE ENTRY FOR COLON AND RECTAL SURGERY

Click on the Case Entry tab and the Case/Encounter Menu will display. To add new case/encounters, click on Add.



After you click on the Add link, the Case/encounter Entry page will display. If you are a resident your name will automatically appear. If you are the administrator you will be able to choose the resident from the drop down list.



Fields

Resident:	Resident name is automatically entered based on your login. *
Attending:	Select the Attending Physician using the down arrow.
Institution:	Select the Institution where the case/encounter was performed using the down arrow.
Resident Year:	Enter the year of training within the specialty (This is not the post graduate year in training) at the time of the case/encounter. The year will default to the year entered on the resident setup screen by your program director or residency coordinator
Resident Role:	Select the Role from the drop down list: Surgeon
Date:	Enter Date of case/encounter including / or – to separate Month/day/year (Format: mm/dd/yyyy).
Case ID:	An identifier to that patient.
Code:	All CPT/ICD9 codes are in the system. The RRC reviews all codes and maps them to an area and type. Those codes that are not mapped to an area and type will fall under a category called unassigned.
Full Code Desc.	This is the full CPT/ICD9 description. This field is populated by the database based on the CPT/ICD9 code you choose
Area:	The area is either diagnosis or Procedures. This field is populated by the database based on the CPT/ICD9 code you choose
Type:	The type is either diagnosis or Procedures. This field is populated by the database based on the CPT/ICD9 code you choose
Comment:	This can be notes about the patient and/or procedure. This is not a mandatory field.

* If you are logging in as an administrator, you can click on the drop down box and choose the resident you are entering cases for.

For the case/encounter you are entering you will choose from the drop down list each of the following: attending; Institution; role and then enter in the resident year (if incorrect), date of the case/encounter and enter in a case ID.

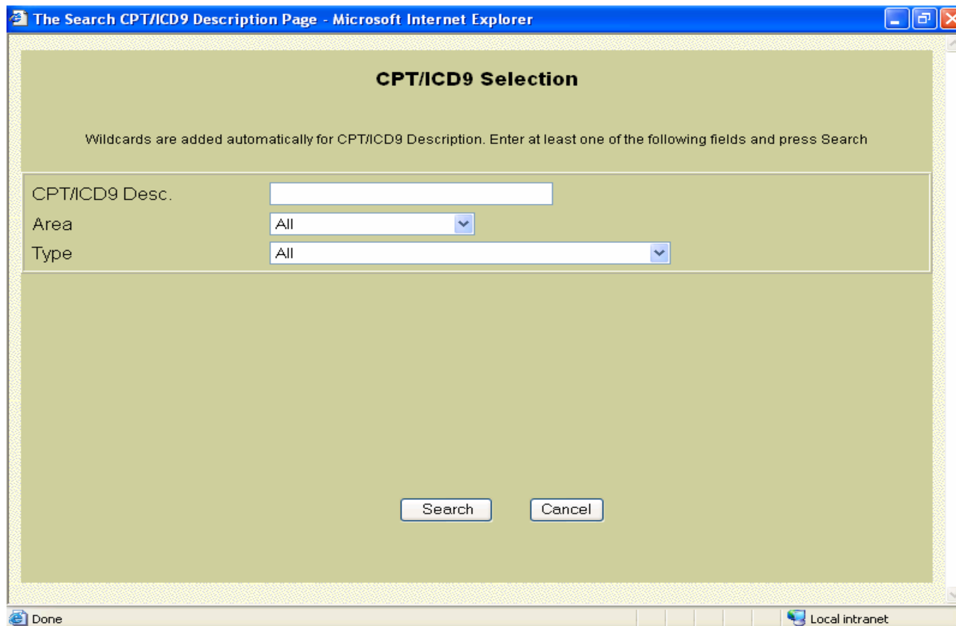
If you are entering a case and you do not find the attending or institution on your list you will need to contact your program director or coordinator to have them added to the list.

If you know the appropriate CPT/ICD9 code(s), in the Code field type the CPT/ICD9 code, and click on the Select button. The system will always move the CPT/ICD9 code from the field always leaving it blank and display it in the Selected Codes List. In the pictured example, ICD9 code 569.85 was entered. If the ICD9 code is valid it will automatically be placed in the Selected Codes list.

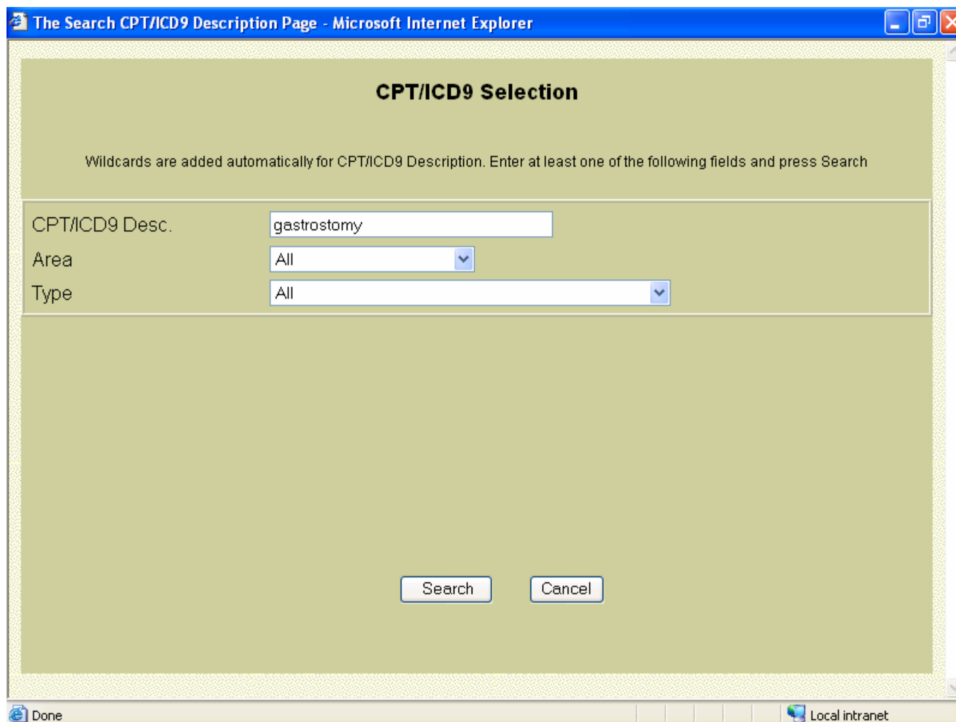
The Selected Codes list allows you to view the full CPT/ICD9 Code Description, Area and type of the CPT/ICD9 code chosen. Click on an ICD9 code in the Selected Code list and the selection will be highlighted. This will then allow you to view the description, area and type for that ICD9 code. To remove the highlighted ICD9 code, click on the Remove Code button.

Searching for an ICD9 Code

If you do not know the CPT/ICD9 code you can do a search. To search for a CPT/ICD9, click on the Search button next to the Code field. The CPT/ICD9 Selection window will display:

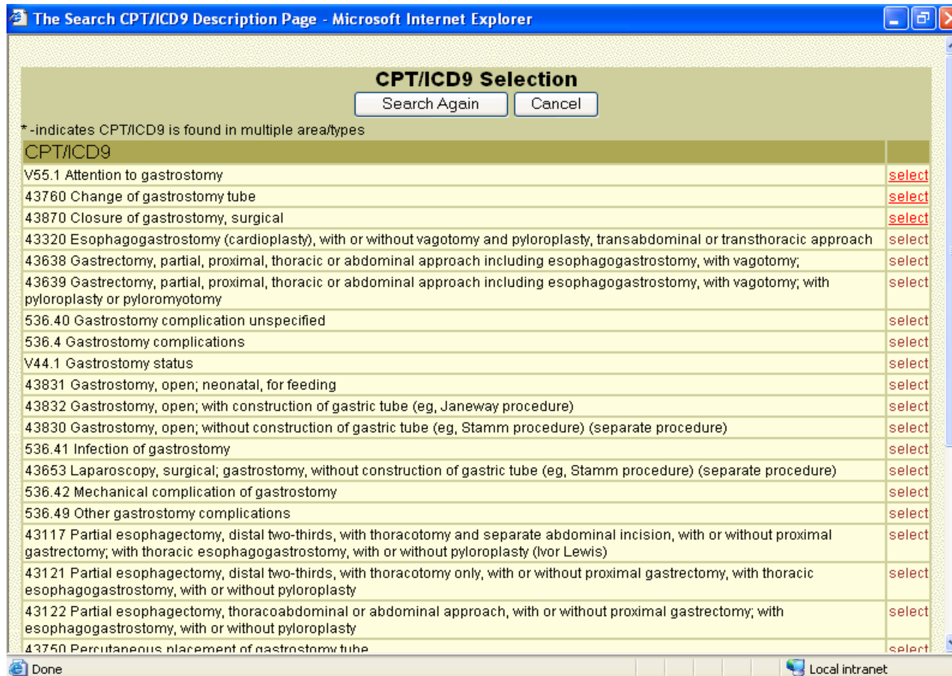


CPT/ICD9 Selection allows the user to look for CPT/ICD9s in multiple ways. A user can search for a specific phrase or word in the description, or leave the CPT/ICD9 Desc. blank, area and type to all. This will allow you to view all ICD9 descriptions available. You may also select an Area and/or Type from the drop-down boxes. Below is an example of entering a word or phrase that exists in the description.



Searching for an ICD9 Code (cont.)

When “gastrostomy” is entered and the Search button is clicked, the results are displayed for all of the CPT/ICD9 descriptions containing the word “gastrostomy”



View the list and choose the CPT/IDC9 code that closely or exactly reflects the procedure/diagnosis done. To help further assist in find the correct code you can use the CTRL key and the F key on your keyboard which will bring up a find function. You could then enter in “vagotomy” and click on find next and the system will highlight the first instance it finds. Click on find next again and it will find the next instance of “vagotomy”. Click on the select link and the CPT/ICD9 code is returned to the case/encounter entry screen and entered in the selected CPT/ICD9 Codes list.

NOTE: Each case/encounter requires one procedure (CPT) code and one diagnosis (ICD9) code.

To assist with data entry, the attending, institution, year in program, date, and role have remained pre-filled from the previous entry. Change these fields as needed. When finished entering all of your case/encounter data, click on the Cancel button to exit to the Case Entry menu,

CASE LOG SYSTEM Guidelines

The RRC has re-affirmed that it will require every program to use the ACGME on line procedure logs for data collection beginning July 1, 2005. All patients should be entered with one diagnosis and one procedure. The system is HIPPA compliant, and there are business agreements in place between the covered entities and the sponsoring institution, which were created by the ACGME. As it now stands, there are many inconsistencies as to how data is collected in specialties not using the ACGME site, and this is a frequent cause of concern and subsequent citations. The ACGME data depository thus provides a mechanism that allows for training programs to comply with program requirements and provides a uniform mechanism to verify the clinical training of residents among programs. To avoid issues of patient confidentiality and use of patient identifiers such as SS numbers or hospital numbers, residents in a given program can identify data without the use of this information. Programs will not be required to use patient identifiers but should create an internal system to collect data so that program directors will be able to monitor the input of data. At the time of a site visit, the program director may be asked to produce the lists to verify the data in the PIF. PDA software will be available for a $25 user fee. Residents will be asked to sign a waiver at the initiation of data collection.