



## CASE ENTRY FOR ALLERGY AND IMMUNOLOGY

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

The screenshot shows the ACGME web interface with the 'Case Entry' tab selected. The 'Case/Encounter Menu' is displayed, listing the following options:

- Case/Encounters
  - [Add](#)
  - [Search/Update](#)
  - [Update Case/Encounter Year](#)
  - [Download Case/Encounters](#)

At the bottom of the menu, there is a note: "Please report any problems or suggestions to the [OPLoq@acgme.org](mailto:OPLoq@acgme.org)."

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.

The screenshot shows the 'Case/Encounter Entry' form. The form includes the following fields and controls:

- Resident:** A dropdown menu showing 'A&I Resident Number 1'.
- Resident Year:** A text input field containing '1'.
- Attending:** A dropdown menu showing '< Please select a value >'.
- Setting:** A dropdown menu showing 'Outpatient Followup'.
- Institution:** A dropdown menu showing '< Please select a value >'.
- Case Type:** A dropdown menu showing 'Adult (18 and older)'.
- Date:** A text input field containing '3/31/2004'.
- Case Id:** A text input field.
- ICD9 Code:** A text input field with 'Select' and 'Search' buttons.
- Comments:** A large text area for entering notes.
- Buttons:** 'Save', 'Help', 'Clear', and 'Cancel' buttons.
- Selected ICD9 Codes:** A section with a checkbox for 'Principal' and a message: "No ICD9 Code Descriptions have been currently selected for display." Below this is a 'Remove ICD9 Code' button.
- Full ICD9 Code Desc:** A text input field.
- Area:** A dropdown menu.
- Type:** A dropdown menu.

## **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 your categorical year in the specialty (This is not your 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
Setting:	Select Setting from the drop down list: Inpatient Follow-up; Inpatient New Patient; Outpatient Follow-up; Outpatient New Patient.
Case Type:	Select Adult (18 or older) or Pediatric (Under 18).
Date:	Enter Date of case/encounter including / or – to separate Month/day/year (Format: mm/dd/yyyy).
Case ID:	An identifier to that patient.
ICD9 Code:	All 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.
Principal:	You can enter more than one ICD9 code on a case but you will need to mark one as your principal diagnosis or procedure.
Full ICD9 Desc.	This is the full ICD9 description. This field is populated by the database based on the ICD9 code you choose
Area:	The area is the broadest category of procedure/diagnosis the RRC is tracking
Type:	The type is the specific procedure/diagnosis that the RRC is tracking
Comment:	This can be notes about the patient and/or procedure/encounter. 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; setting; case type; and then enter in the resident year (if incorrect), date of the case/encounter, and case ID (not required).

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 ICD9 code(s), in the ICD9 code field type the ICD9 code, and click on the Select button. The system will always move the ICD9 code from the field always leaving it blank and display it in the Selected ICD9 Codes List. In the pictured example, ICD9 code 786.2 was entered. If the ICD9 code is valid it will automatically be placed in the Selected ICD9 Codes list.

The screenshot displays the ACGME Case Entry interface. At the top, there are navigation tabs: Login, Case Entry (selected), Reports, Handheld, and Help. The main section is titled "Case/Encounter Entry" and contains the following fields:

- Resident: A&I Resident, Number 1. (dropdown)
- Resident Year: 1 (text input)
- Attending: Attending, Number 1. (dropdown)
- Setting: Outpatient Followup (dropdown)
- Institution: Institution Number 1 (dropdown)
- Case Type: Adult (18 and older) (dropdown)
- Date: 3/31/2004 (text input)
- Case Id: 12345 (text input)
- ICD9 Code: (text input) with "Select" and "Search" buttons.
- Comments: (text area)

Below these fields are "Save", "Help", "Clear", and "Cancel" buttons. The "Selected ICD9 Codes 2" section includes a checkbox for "Principal" (checked) and a list of codes:

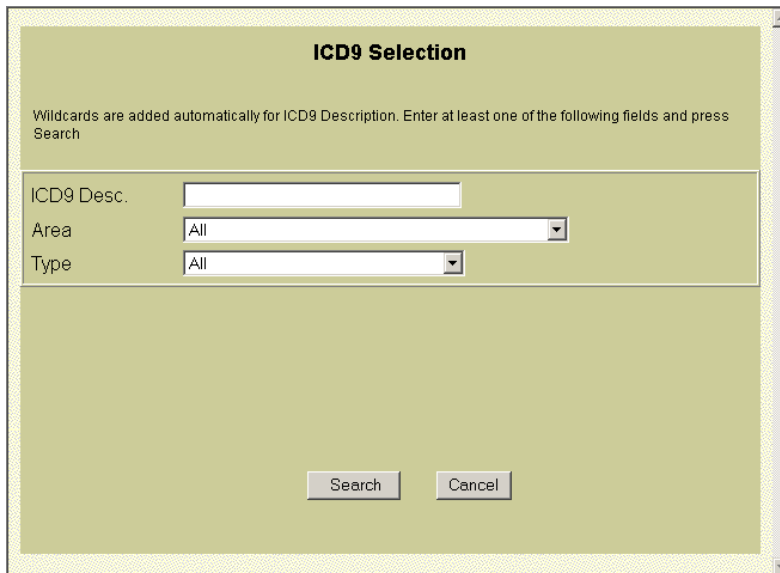
- \* 786.2 Cough (highlighted)
- 466.0 Acute bronchitis

A "Remove ICD9 Code" button is located below the list. The "Full ICD9 Code Desc" field shows "Cough". At the bottom, the "Area" is set to "Diagnoses" and the "Type" is set to "Asthma".

The selected ICD9 Codes list allows you to view the full ICD9 Code Description, Area and Type of the ICD9 code chosen. Click on an ICD9 code in the selected ICD9 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 ICD9 button.

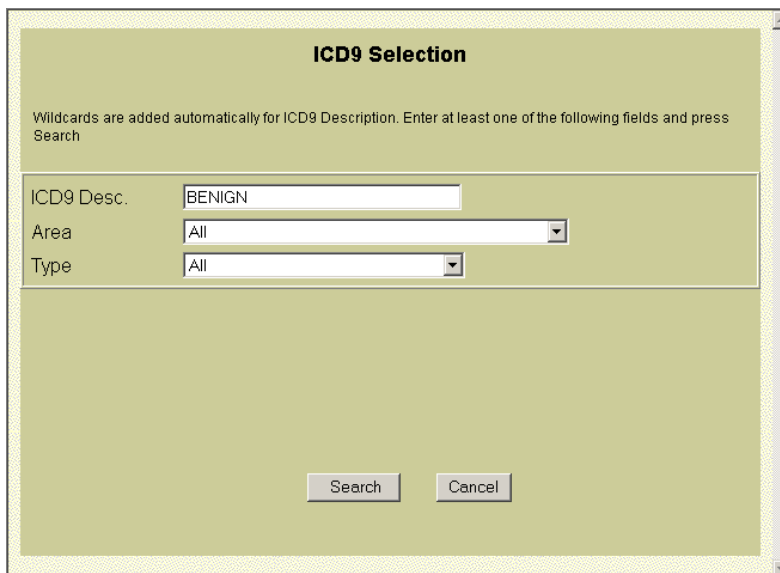
## Searching for an ICD9 Code

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



The screenshot shows a window titled "ICD9 Selection" with a light green background. At the top, it says "Wildcards are added automatically for ICD9 Description. Enter at least one of the following fields and press Search". Below this, there are three input fields: "ICD9 Desc." (a text box), "Area" (a dropdown menu), and "Type" (a dropdown menu). All three fields currently contain the text "All". At the bottom of the window, there are two buttons: "Search" and "Cancel".

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 to see all of the CPT/ICD9 codes available, you can leave the CPT/ICD9 description blank and select "all" for the Area and Type. 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.



This screenshot is identical to the one above, but the "ICD9 Desc." text box now contains the word "BENIGN". The "Area" and "Type" dropdown menus still show "All". The "Search" and "Cancel" buttons remain at the bottom.

When "benign" is entered and the Search button is clicked, the results are displayed for all of the ICD9 descriptions containing the word "benign" (see next page):

## Searching for an ICD9 Code (cont.)

ICD9	
642.03 Antepartum benign essential hypertension	<a href="#">select</a>
401.1 Benign essential hypertension	<a href="#">select</a>
642.00 Benign essential hypertension complicating pregnancy childbirth and the puerperium unspecified as to episode of care	<a href="#">select</a>
642.0 Benign essential hypertension complicating pregnancy, childbirth, and the puerperium	<a href="#">select</a>
642.01 Benign essential hypertension with delivery	<a href="#">select</a>
642.02 Benign essential hypertension with delivery with postpartum complication	<a href="#">select</a>
404.1 Benign hypertensive heart and renal disease	<a href="#">select</a>
404.11 Benign hypertensive heart and renal disease with congestive heart failure	<a href="#">select</a>
404.13 Benign hypertensive heart and renal disease with congestive heart failure and renal failure	<a href="#">select</a>
404.12 Benign hypertensive heart and renal disease with renal failure	<a href="#">select</a>
404.10 Benign hypertensive heart and renal disease without congestive heart failure or renal failure	<a href="#">select</a>
402.1 Benign hypertensive heart disease	<a href="#">select</a>
402.11 Benign hypertensive heart disease with congestive heart failure	<a href="#">select</a>
402.10 Benign hypertensive heart disease without congestive heart failure	<a href="#">select</a>
403.1 Benign hypertensive renal disease	<a href="#">select</a>
403.11 Benign hypertensive renal disease with renal failure	<a href="#">select</a>
403.10 Benign hypertensive renal disease without renal failure	<a href="#">select</a>
348.2 Benign intracranial hypertension	<a href="#">select</a>

View the list and choose the ICD9 code that closely or exactly reflects the diagnosis done. To further assist in finding 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 "intracranial" 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 "intracranial". Click on the select link and the ICD9 code is returned to the case/encounter entry screen and entered in the selected ICD9 Codes list.

### **NOTE: You may enter more than one ICD9 code per case/encounter**

The RRC has added a check box to indicate the principal diagnosis. Once you have added the ICD9 codes for that case/encounter you will need to mark which ICD9 code is the principal diagnosis.

- The Principal diagnosis is the main reason for the visit or admission.
- The Secondary diagnoses are incidental, related, or other diagnoses addressed during this visit.

All procedure data are counted equally. If you enter only procedures for a patient encounter (no diagnosis), the system will require you to select one as principal, but on the report they will all count equally. Procedures are not broken down by principal and secondary.

Highlight the code that you would like to be marked as your principal code and click on the Principal check box. An \* next to the ICD9 code indicates the Principal credit.

Once all the ICD9 codes and fields have been entered, click on the save button or to exit without saving click Cancel.

To assist with data entry, the attending, institution, year in program, date, setting, and case type 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 Entry for Allergy & Immunology

## **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, 2004. All patients should be entered and a single ICD-9 code will be sufficient. Residents may add up to three codes; one of which is the primary diagnosis and the remaining two are secondary diagnoses. 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.

- **What is a "new" versus "follow-up" patient for purposes of the procedure logs?**

A new patient is defined as "new" to the resident, even though the patient is considered a follow-up for billing and the attending. The ACGME website will contain a dropdown menu for inpatient-follow-up, inpatient new patient, outpatient follow-up and outpatient new patient.

- **Is a patient allowed ONE diagnosis only for the purposes of logging procedure codes?**

Up to three diagnoses can be listed for a given patient if they pertain, but the patient is only counted once for resident numbers and there should be one primary diagnosis.

- **Are all ICD9 codes in the System?**

All 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.