

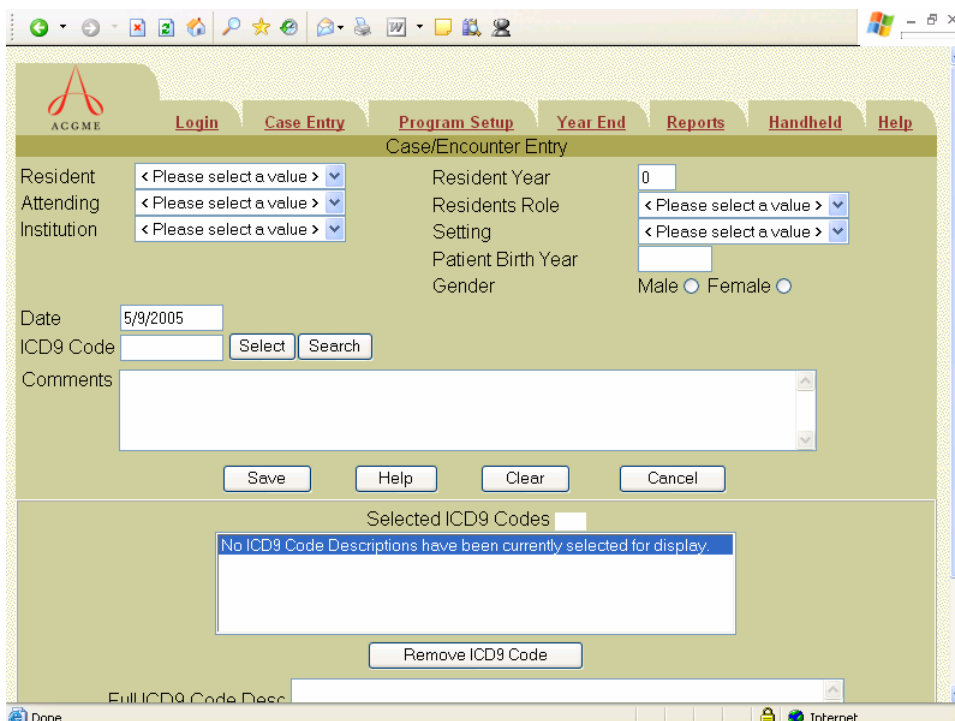
## CASE ENTRY FOR NEUROLOGY/NEURODEVELOPMENT DISABILITIES\CHILD



Click on the Case Entry tab and the Case/Encounter Menu will display. To add new cases/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.



## CASE ENTRY FOR NEUROLOGY/NEURODEVELOPMENT DISABILITIES\CHILD

## **Fields**

Resident:	Resident name is automatically entered based on your login. *
Attending:	Select the Attending Physician using the down arrow.
Institution:	Select the Institution of the case/encounter
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
Resident Role:	Select Role using the down arrow. Choose follow-up or New Patient
Setting:	Select setting using the down arrow. Emer. Consult; Inpatient Consult, Inpatient primary, OP Continuity, OP Neurology Clinic
Patient Birth Year:	Indicate the Patient's Birth Year.
Gender:	Indicate Male or Female
Procedure Date:	Enter Date of case/encounter including / or – to separate Month/day/year (Format: mm/dd/yyyy).
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.
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 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; resident role, setting, patient birth year and then enter in the resident year (if incorrect), date of the case/encounter and gender.

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 Codes(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 Procedures List. In the pictured example, ICD9 code 300.0 was entered. If the CPT code is valid it will automatically be placed in the Selected CPT list.

The screenshot shows the 'Case/Encounter Entry' form in the AGGME system. The form is divided into several sections. At the top, there are navigation tabs: Login, Case Entry, Program Setup, Year End, Reports, Handheld, and Help. The main form area is titled 'Case/Encounter Entry' and contains the following fields and controls:

- Resident:** A dropdown menu with 'Neurology, Test X' selected.
- Attending:** A dropdown menu with 'One, Attending O.' selected.
- Institution:** A dropdown menu with '< Please select a value >' selected.
- Resident Year:** A text input field containing '2'.
- Residents Role:** A dropdown menu with 'Followup' selected.
- Setting:** A dropdown menu with 'Inpatient Consult.' selected.
- Patient Birth Year:** An empty text input field.
- Gender:** Radio buttons for 'Male' and 'Female', with 'Male' selected.
- Date:** A text input field containing '5/9/2005'.
- ICD9 Code:** A text input field containing '300.0', followed by 'Select' and 'Search' buttons.
- Comments:** A large text area for entering notes.
- Buttons:** 'Save', 'Help', 'Clear', and 'Cancel' buttons are located below the comments field.

Below the main form area, there is a section titled 'Selected ICD9 Codes' with a counter showing '1'. A list box contains the entry '300.0 Anxiety states', which is highlighted. Below this list box is a 'Remove ICD9 Code' button. At the bottom of the form, there are two more fields:

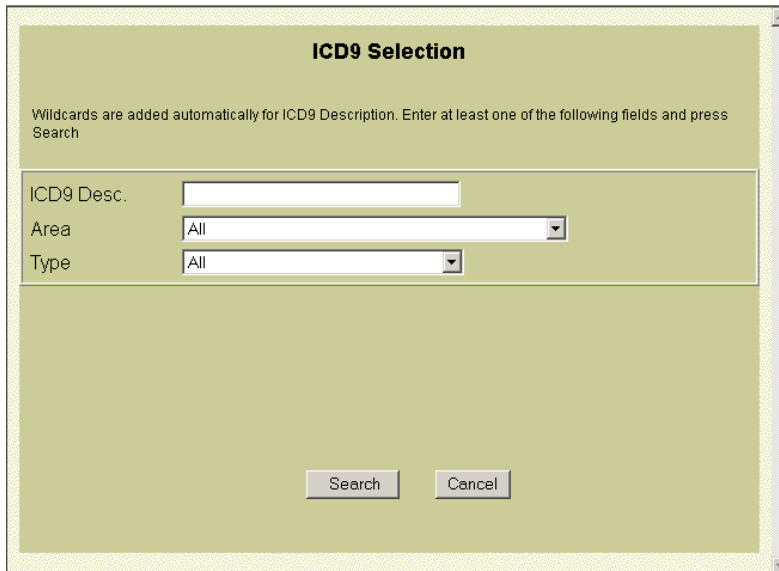
- Full ICD9 Code Desc:** A text area containing 'Anxiety states'.
- Area:** A dropdown menu with 'Psychiatric Conditions' selected.
- Type:** A dropdown menu with 'Blank' selected.

The bottom of the screenshot shows the Windows taskbar with the 'Done' button and the 'Internet' icon.

The Selected ICD9 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 Code button.

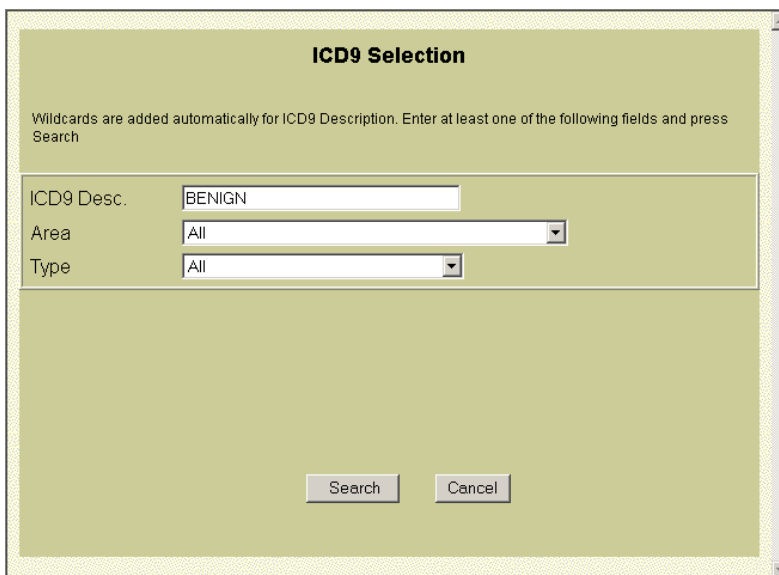
## Searching for an ICD9 Code

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 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 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 previous one, 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.)

**CPT Selection**

\* - indicates CPT is found in multiple area/types

CPT	
01444	Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm
01652	Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm
35011	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35001	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision
35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta
35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, exte
35091	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, re
35141	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)
35121	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery
35131	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)
35021	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision
35161	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, other arteries
35151	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, popliteal artery
35045	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, radial or ulnar artery
35111	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, splenic artery
35005	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, vertebral artery

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 "celiac" 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 "celiac". 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**

Once all the ICD9 codes have been entered, click on the save button to save the procedure. To exit without saving click Cancel.

To assist with data entry, the attending, institution, year in program, resident's role, procedure date, and patient type have remained pre-filled from the previous entry. Change these fields as needed. When finished entering all of your procedure data, to exit to the Procedure menu, click on the Cancel button.

## Resident Case Log Ground Rules

### General Information:

- The resident is responsible for logging in his/her own patient data.
- A log-in code and password is assigned to each resident by the program director.
- The program director is able to review each resident's data file, but will be unable to alter or change information entered.
- Depending upon computer/internet access, it is recommended that residents keep a written record of patients evaluated until the information can be entered by the resident. (2/2002 currently could keep information of personal device).

### Data Collection:

- Residents should enter the date of the evaluation, institution, name of attending physician, clinical setting, patient year of birth, and diagnosis(es).
- Diagnosis should include primary and secondary neurological diagnoses carried by each patient (e.g., complex partial seizures and migraine headaches) with a limit of no more than three per patient.
- The diagnosis(es) may either be entered using the tab for the categories of disease provided or typed in directly by the resident.

### Clinical Setting:

- A resident should enter any patient for whom he/she has assumed a significant management responsibility; a rule of thumb is that the interaction should have been important enough to warrant a written note in the chart.
  - Inpatient:
    - Consult service
    - Primary service
    - Note:** ANY SINGLE PATIENT IS TO BE ENTERED ONLY ONCE/RESIDENT.  
INTENSIVE CARE PATIENTS ARE LISTED SEPARATELY.
  - Outpatient:
    - Clinic:
      - New Patient
      - Follow up If new to resident or if seen in continuity clinic where each visit should be documented

**Note:** ANY SINGLE PATIENT IS TO BE ENTERED ONLY ONCE/RESIDENT EXCEPT FOR CONTINUITY CLINIC PATIENTS WHO ARE TO BE ENTERED EACH TIME THEY ARE SEEN.  
CONTINUITY CLINIC PATIENTS ARE LISTED SEPARATELY.  
ER CONSULTS ARE LISTED SEPARATELY.

- Consult:
  - Emergency
  - Non-neurology outpatient clinics

- If admitted from an outpatient setting, the patient can be counted as an outpatient and an inpatient if two different residents evaluate that patient (e.g., One resident evaluates the patient in the emergency room and another resident admits and/or manages the patient on the inpatient service).
- If admitted from an outpatient setting, the patient can be counted only as an inpatient if the same resident evaluated the patient as an outpatient and also manages or consults on that patient on an inpatient service.
- Only residents who are directly involved in the examination and management of a patient may count that patient in their log. Work/attending rounds do not count as patient encounters with the exception for those residents who have examined the patient and are directly involved in the management (e.g., admitting resident and upper-level resident).
- Patients who are evaluated by residents during cross-coverage periods (call and days off) should be counted by the cross-covering resident if their cross coverage necessitates significant and active management responsibility (e.g. if called to assess and treat a worsening neurologic deficit after admission for stroke, the cross-covering resident should enter the patient in his/her log). Passive responsibility for patients does not qualify.