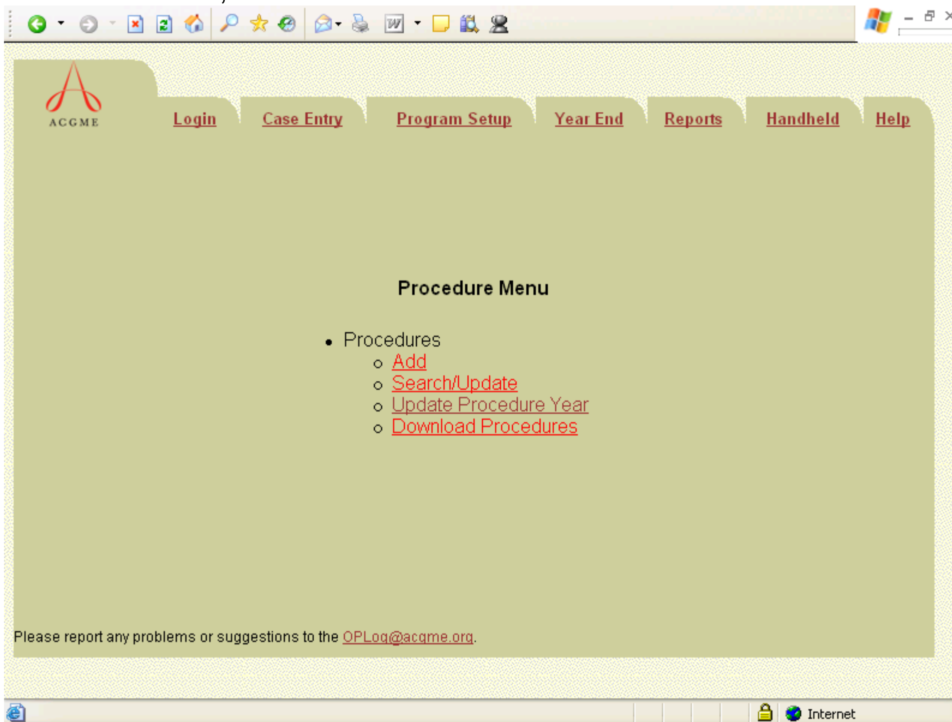
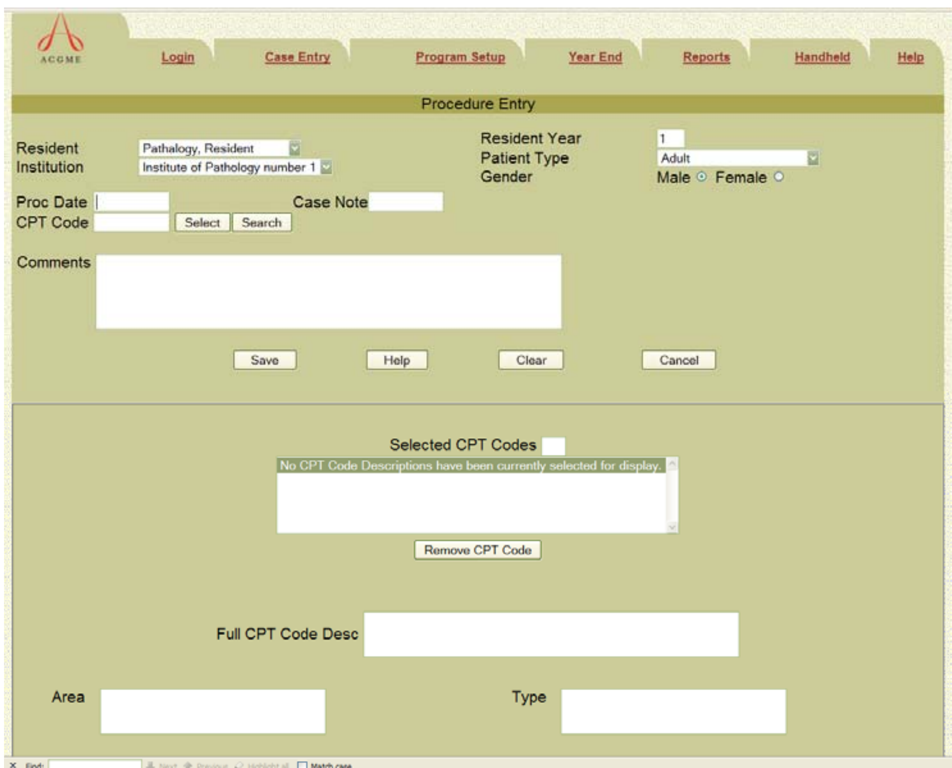
CASE ENTRY FOR PATHOLOGY

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



After you click on the Add link, the Procedure 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 PATHOLOGY

Fields

Resident:	Resident name is automatically entered based on your login. *
Institution:	Select the Institution using the down arrow.
Resident Year:	Enter your categorical year of the specialty (This is not your 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
Patient Type:	Select using the down arrow adult or pediatric.
Procedure Date:	Enter Date including / or – to separate month/day/year. Format is mm/dd/yyyy.
Case Note:	An identifier to that patient.
CPT Code:	All CPT 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 CPT Desc.	This is the full CPT description. This field is populated by the database based on the CPT code you choose
Area:	The area is either CPT code or Procedures. This field is populated by the database based on the CPT code you choose
Type:	The type is either CPT code or Procedures. This field is populated by the database based on the CPT 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 procedure you are entering you will choose from the drop down list each of the following: Institution, resident role, patient type, and then enter in the resident year (if incorrect), date of procedure and enter in a case note.

If you are entering a case and you do not find 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 code(s), in the CPT code field type the CPT code and click on the Select Button. The system will always move the CPT code from the field always leaving it blank and display it in the Selected CPT Codes List. In the pictured example, CPT code 15782 was entered. If the CPT code is valid it will automatically be placed in the Selected CPT list.

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

ACGME
Login Case Entry Program Setup Year End Reports Handheld Help

Procedure Entry

Resident: Pathalogy, Resident
Institution: Institute of Pathology number 1
Resident Year: 1
Patient Type: Adult
Gender: Male Female
Proc Date
Case Note
CPT Code Select Search
Comments
Save Help Clear Cancel

Selected CPT Codes
No CPT Code Descriptions have been currently selected for display.
Remove CPT Code

Full CPT Code Desc
Area
Type

Find: Next Previous Highlight all Match case

Entering procedure guidelines

Autopsy Codes

1. Enter the appropriate code for non-forensic autopsy when you were actively involved in each of the following components of a complete autopsy:

   a. Review of medical history and circumstances of death
   b. External examination of the body
   c. Gross dissection
   d. Review of microscopic and laboratory findings
   e. Preparation of written descriptions of the gross and microscopic findings
   f. Development of an opinion regarding the cause of death
   g. Review of the autopsy report with a member of the teaching staff

2. Enter the appropriate code when you participated each of these components for a forensic autopsy.

Optional: You may enter codes for autopsies in which you were not involved in all seven of these components using the appropriate code for gross examination only or limited autopsy. **NOTE**: If microscopic findings are not indicated for a forensic autopsy, you may still enter a CPT code for a compete autopsy.

Bone Marrow Codes

1. Enter the appropriate code when you perform a bone marrow aspiration.
2. Enter the appropriate code when you perform a bone marrow biopsy.

Optional: You may enter codes for the interpretation of a biopsy or aspirate, even if you did not perform the procedure.

FNA Codes

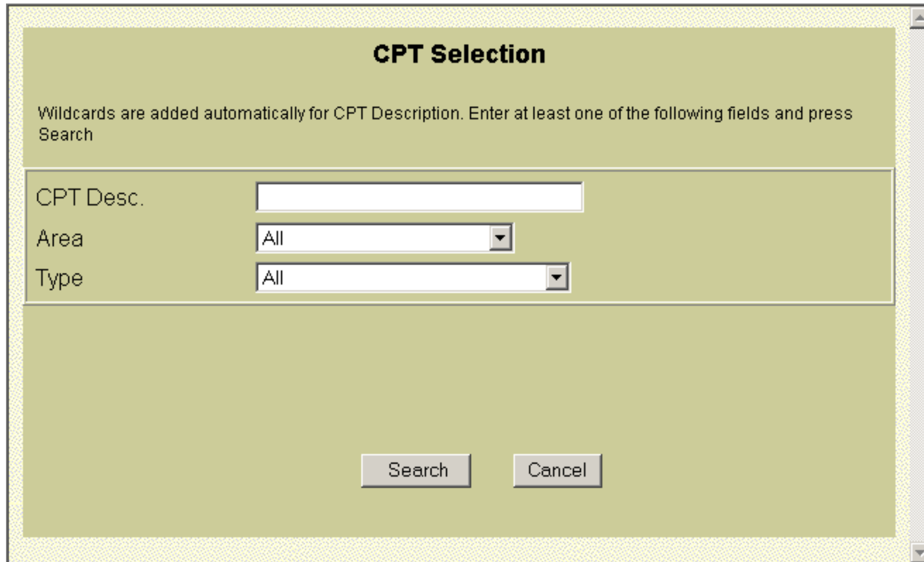
Enter the appropriate code when you perform a fine needle aspiration.

Other Codes

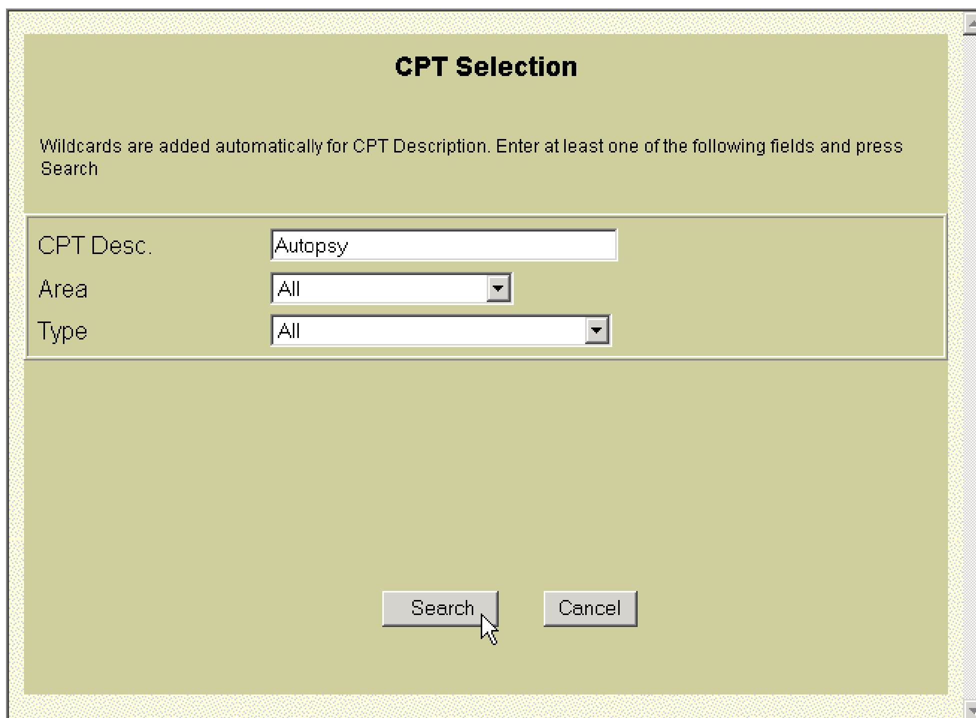
You may enter any valid CPT code. For example, you may keep track of consultations, clinical pathology tests, identification of microorganisms, special stains, or surgical specimens examined. Tracking your experience in these areas, however, is not required.

Searching for a CPT Code

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



CPT Selection allows the user to look for CPT s in multiple ways. A user can search for a specific phrase or word in the description, or leave the CPT Desc. blank, area and type to all, this will allow you to view all CPT 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.



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

CPT Selection

Search Again | Cancel

*-indicates CPT is found in multiple area/types

CPT	
88028 Necropsy (autopsy), gross and microscopic; infant with brain	select
88029 Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	select
88025 Necropsy (autopsy), gross and microscopic; with brain	select
88027 Necropsy (autopsy), gross and microscopic; with brain and spinal cord	select
88020 Necropsy (autopsy), gross and microscopic; without CNS	select
88012 Necropsy (autopsy), gross examination only; infant with brain	select
88016 Necropsy (autopsy), gross examination only; macerated stillborn	select
88014 Necropsy (autopsy), gross examination only; stillborn or newborn with brain	select
88005 Necropsy (autopsy), gross examination only; with brain	select
88007 Necropsy (autopsy), gross examination only; with brain and spinal cord	select
88000 Necropsy (autopsy), gross examination only; without CNS	select
88036 Necropsy (autopsy), limited, gross and/or microscopic; regional	select
88037 Necropsy (autopsy), limited, gross and/or microscopic; single organ	select
88045 Necropsy (autopsy); coroner's call	select
88040 Necropsy (autopsy); forensic examination	select
88099 Unlisted necropsy (autopsy) procedure	select

Search Again | Cancel

View the list and choose the CPT code that closely or exactly reflects the 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 “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 CPT code is returned to the case/encounter entry screen and entered in the selected CPT Codes list.

NOTE: You may enter more than one CPT code per patient

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

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 with a CPT code(s). 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.