

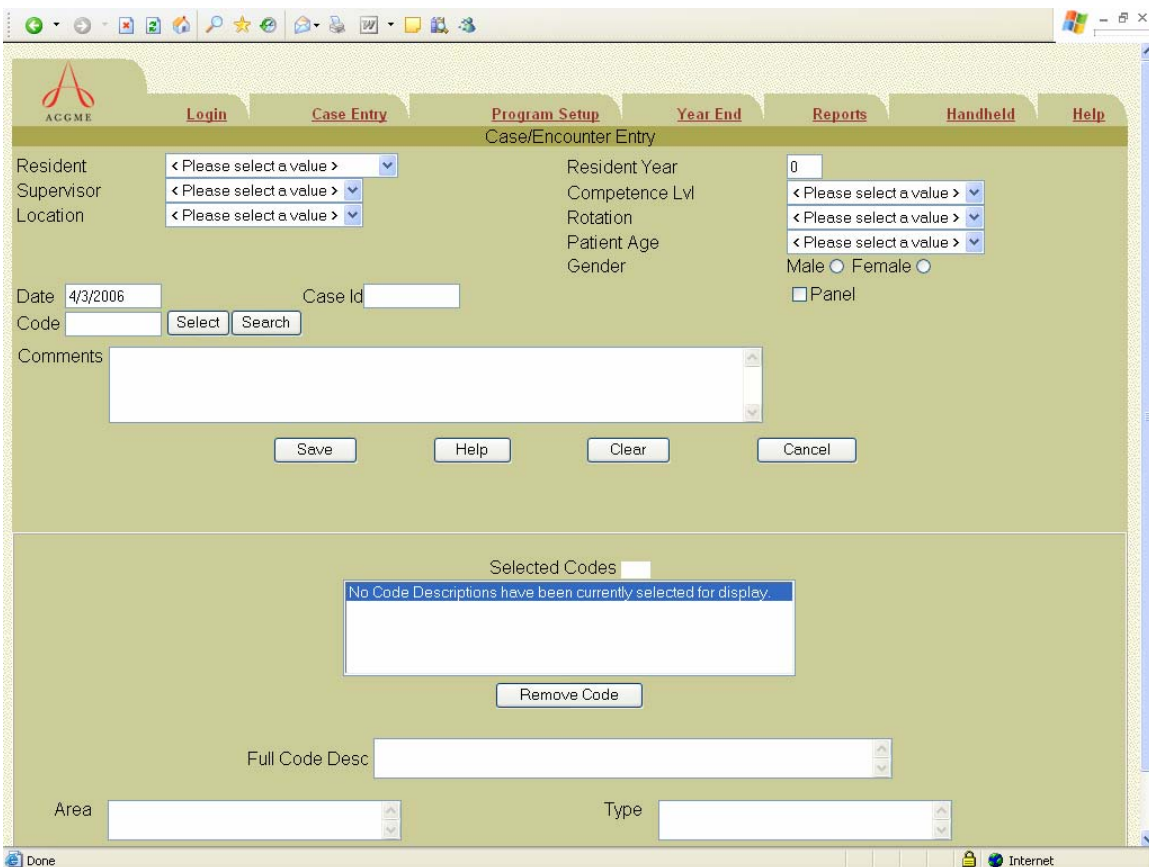
## CASE ENTRY FOR PEDIATRICS AND COMBINED MED/PEDS



Click on the “Case Entry” tab and the Case/Encounter Entry Menu will display. To add new Cases, 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 PEDIATRICS AND COMBINED MED/PEDS

## **Fields**

Resident:	Resident name is automatically entered based on your login. *
Location:	Select the Location where the case was performed using the pull down menu.
Supervisor:	Select the Supervisor using the pull down menu. The System has been changed so that programs/residents can indicate the name of the specific individual who supervised the resident during the procedure/encounter. The previous list of supervisors (attending, other, other supervising resident, PL-2, PL-3, or subspecialty resident) will remain, but programs will have the option of adding the specific names of the various potential supervisors. While the System requires a supervisor to be indicated, it is the program's choice as to whether they want their residents to use the generic options or enter the individual
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
Competence Lvl:	Select from the drop down list; The options are: N/A, practice independently, and practice with supervision.  The N/A option is available because the System has been deliberately designed to allow residents the capability to enter patient encounters other than just procedures (i.e. diagnoses) and the competence level would not necessarily apply in these instances.
Rotation:	Select from the dropdown list. The options are: continuity, inpatient, NICU, Other, PICU
Patient Age:	Select the Patient Age from the pull down menu.
Gender:	Select either male or female
Date:	Enter Date of case/encounter including / or – to separate Month/day/year (Format: mm/dd/yyyy).
Case ID:	An identifier to that patient. Case ID is a 20-character field that is required. It can be used to search for specific cases or tracking patients. It is also used to avoid making duplicate entries.
Panel:	Used to indicate whether the patient is part of your panel.
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 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: Supervisor; Location; Competence Lvl; Rotation; Patient Age; and Gender. Then enter in the resident year (if incorrect), date of the case/encounter and enter in a 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 CPT/ICD9 code(s), in the CPT/ICD9 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 CPT/ICD9 Codes List. In the pictured example, CPT code 32002 and ICD code 789.60 were entered. If the ICD9 code is valid it will automatically be placed in the Selected ICD9 Codes list.

The screenshot shows the ACCME Case/Encounter Entry form. The form is divided into several sections. At the top, there are tabs for Login, Case Entry, Program Setup, Year End, Reports, Handheld, and Help. The Case Entry section contains the following fields:

- Resident: Pedsres, Test
- Supervisor: Independent Supervisor
- Location: Pediatric Institute
- Resident Year: 2
- Competence Lvl: Practice Independently
- Rotation: Continuity
- Patient Age: months 6 - 12
- Gender: Male (selected), Female, Panel
- Date: 4/3/2006
- Case Id: 12345-6
- Code: (empty)
- Comments: (empty text area)

Below the form, there are buttons for Save, Help, Clear, and Cancel. The Selected Codes list shows two codes:

- 32002 Thoracentesis with insertion of tube with or without
- 789.60 Abdominal tenderness unspecified site

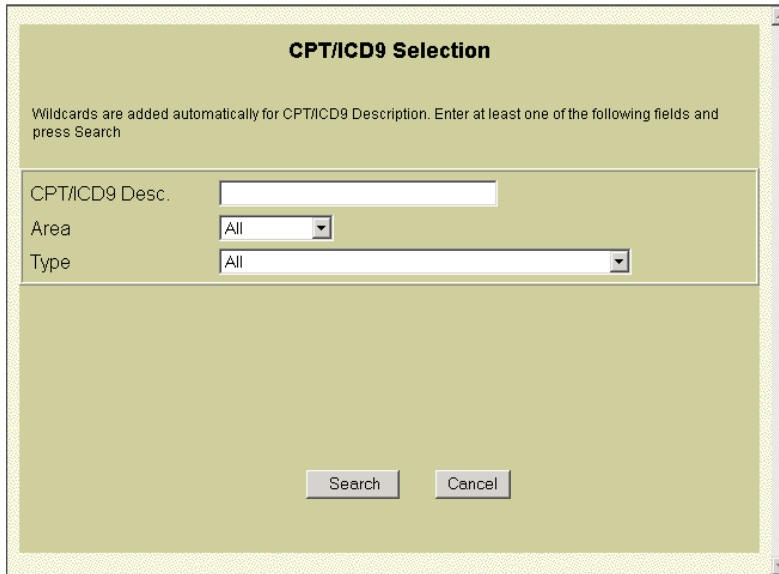
The Full Code Desc field shows Abdominal tenderness unspecified site. The Area is set to Diagnoses and the Type is Disease of the Digestive System.

The selected Codes list allows you to view the full CPT and ICD9 Code Descriptions, Area and Type of the CPT and ICD9 code chosen. Click on an CPT or 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 CPT or ICD9 code. To remove the highlighted CPT or ICD9 code, click on the Remove Code button.

The list of procedures tracked in the System has been further refined and narrowed. Residents will only be asked to enter those procedures for which the RRC needs to capture national level data. As a result, the procedures have been grouped and listed in three categories. The first group contains procedures that need to be tracked throughout training (endotracheal intubation, umbilical artery catheter, umbilical vein catheter, and lumbar puncture). The second group contains procedures tracked until competence is achieved (arterial puncture, placement of intravenous line, venipuncture, suturing of laceration, splinting of simple dislocation, and bladder catheterization). The last group is the listing of additional procedures. These are procedures that the RRC is not currently requiring be entered, but are listed and available for tracking.

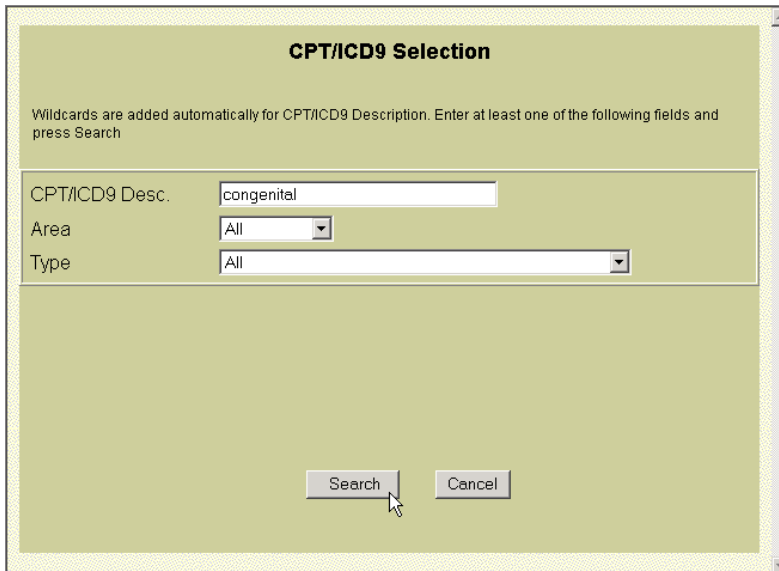
## Searching for a CPT/ICD9 Code

If you do not know the CPT/ICD9 code you can do a search. To search for an CPT/ICD9, click on the Search button next to the CPT/ICD9 code field. The CPT/CD9 Selection window will display:



The screenshot shows a window titled "CPT/ICD9 Selection". Below the title is a message: "Wildcards are added automatically for CPT/ICD9 Description. Enter at least one of the following fields and press Search". There are three input fields: "CPT/ICD9 Desc." which is empty, "Area" which is set to "All", and "Type" which is also set to "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 "CPT/ICD9 Desc." field now contains the word "congenital". A mouse cursor is pointing at the "Search" button.

When "congenital" is entered and the "Search" button is clicked, the results are displayed for all of the code descriptions containing the word "congenital":

**CPT/ICD9 Selection**

\*-indicates CPT/ICD9 is found in multiple area/types

CPT/ICD9	
744.21 Absence of ear lobe congenital	<a href="#">select</a>
756.13 Absence of vertebra congenital	<a href="#">select</a>
759.1 Anomalies of adrenal gland congenital	<a href="#">select</a>
759.2 Anomalies of other endocrine glands congenital	<a href="#">select</a>
746.0 Anomalies of pulmonary valve, congenital	<a href="#">select</a>
759.0 Anomalies of spleen congenital	<a href="#">select</a>
746.01 Atresia of pulmonary valve congenital	<a href="#">select</a>
751.61 Biliary atresia congenital	<a href="#">select*</a>
45100 Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	<a href="#">select</a>
754 Certain congenital musculoskeletal deformities	<a href="#">select</a>
743.53 Chorioretinal degeneration congenital	<a href="#">select</a>
755.58 Cleft hand congenital	<a href="#">select</a>
44322 Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)	<a href="#">select</a>
93531 Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	<a href="#">select</a>
93533 Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	<a href="#">select</a>
93532 Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	<a href="#">select</a>

View the list and choose the CPT or ICD9 code that closely or exactly reflects the procedure or 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 "cleft" 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 "cleft". Click on the select link and the CPT or ICD9 code is returned to the case/encounter entry screen and entered in the selected CPT or ICD9 Codes list.

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

## **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 CPT or ICD-9 code will be sufficient. 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. PDA software will be available for a \$25 user fee. Residents will be asked to sign a waiver at the initiation of data collection.