

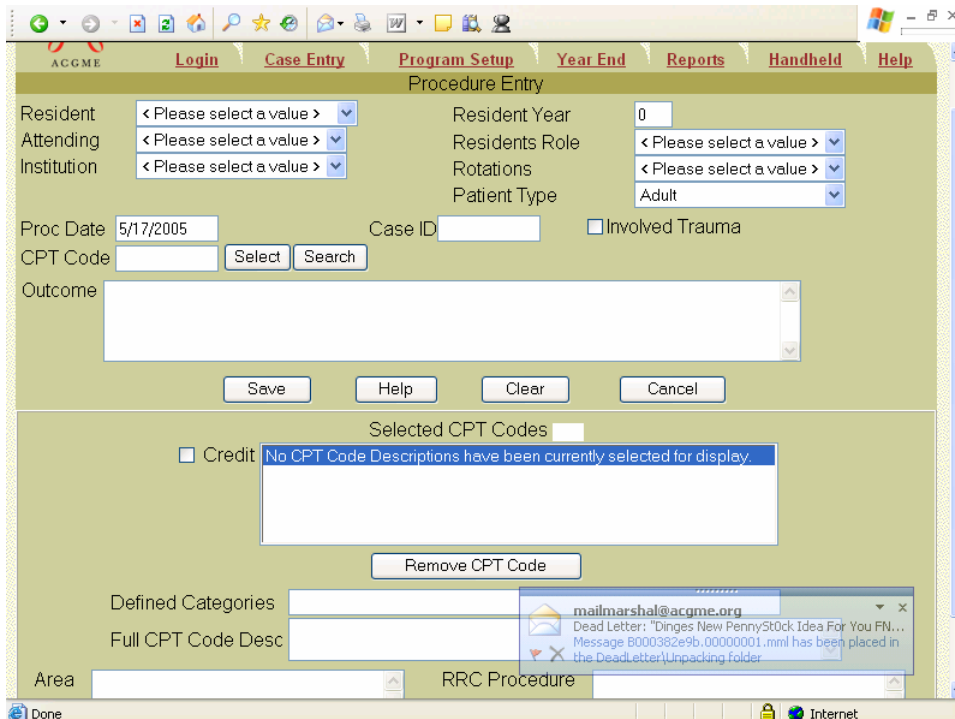
## CASE ENTRY FOR SURGERY GENERAL



CLICK ON THE CASE ENTRY TAB AND THE PROCEDURE MENU WILL DISPLAY. TO ADD NEW PROCEDRES, 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 SURGERY GENERAL

## **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 procedure 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
Resident Role:	Select Role using the down arrow. “ **  SC = Surgeon Chief Year (only cases credited as surgeon during 12 months of Chief Year)  SJ = Surgeon Junior Years (all cases credited as surgeon prior to Chief Year)  TA = Teaching Assistant (more senior resident working with junior resident who takes credit as surgeon)  FA = First Assistant (any instance in which a resident assists at an operation with another surgeon---an attending or more senior resident---responsible for the operation)
Rotation:	During which rotation was this procedure performed.
Patient Type:	Indicate if the procedure was performed on an adult or pediatric patient. The RRC will use to determine if more procedures should count in the pediatric area.
Procedure Date:	Enter Date of procedure including / or – to separate month/day/year. Format mm/dd/yyyy.
Case Id:	Case Id is a 20-character field that is required. It can be used to search for specific procedures or tracking patients. It is also used to avoid making duplicate entries or credit.
Involved Trauma:	The involved trauma checkbox is used to indicate whether a procedure, that does not count in the trauma area, was performed on a trauma patient. The Residency Review Committee (RRC) will monitor these to determine if additional procedures should also count in the trauma area.
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 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 the administrator, you can click on the drop down box and choose the resident you are entering cases for.

\*\* Only one resident may take credit as surgeon for each operation and only for one procedure in a multi-procedure operation. On same patient/same day/same operation a senior resident may take credit as surgeon while another resident takes credit as a First Assistant, or a senior resident may take credit as a Teaching Assistant while a more junior resident takes credit as a surgeon.

## Selecting a CPT code

For the procedure you are entering you will choose from the drop down list each of the following: attending, institution, resident role, rotation, patient type, and then enter in the resident year (if incorrect), date of procedure 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 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 38745 was entered. If the CPT code is valid it will automatically be placed in the Selected CPT Codes list.

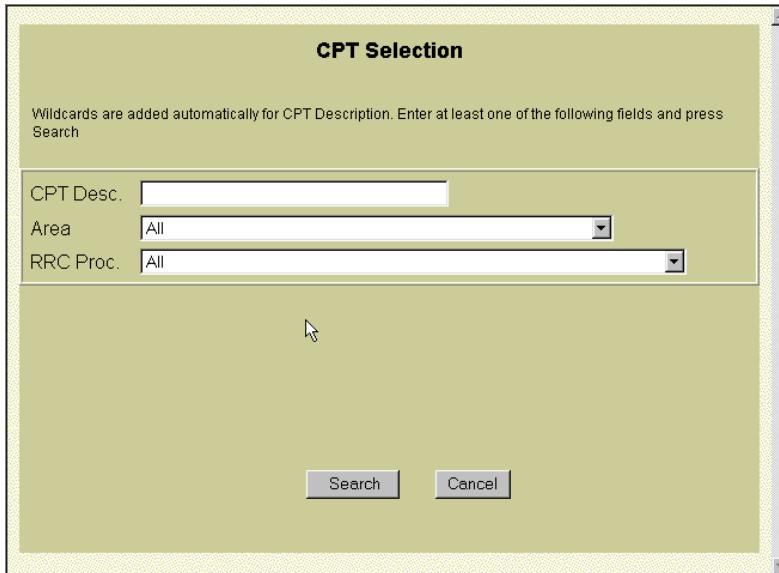
The screenshot shows a web-based form titled "Procedure Entry" with a navigation menu at the top (Login, Case Entry, Program Setup, Year End, Reports, Handheld, Help). The form contains several input fields and buttons:

- Resident: < Please select a value >
- Attending: < Please select a value >
- Institution: < Please select a value >
- Resident Year: 0
- Residents Role: < Please select a value >
- Rotations: < Please select a value >
- Patient Type: Adult
- Proc Date: 5/17/2005
- Case ID: [empty]
- Involved Trauma:
- CPT Code: [empty] with "Select" and "Search" buttons
- Outcome: [empty text area]
- Buttons: Save, Help, Clear, Cancel
- Selected CPT Codes 1:  Credit 38745 Axillary lymphadenectomy, complete
- Remove CPT Code button
- Defined Categories: Skin, Soft tissue and Breast
- Full CPT Code Desc: Axillary lymphadenectomy, complete
- Area: SKIN/SOFT TIS
- RRC Procedure: MAJ LYMPHADENECTOMIES

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.

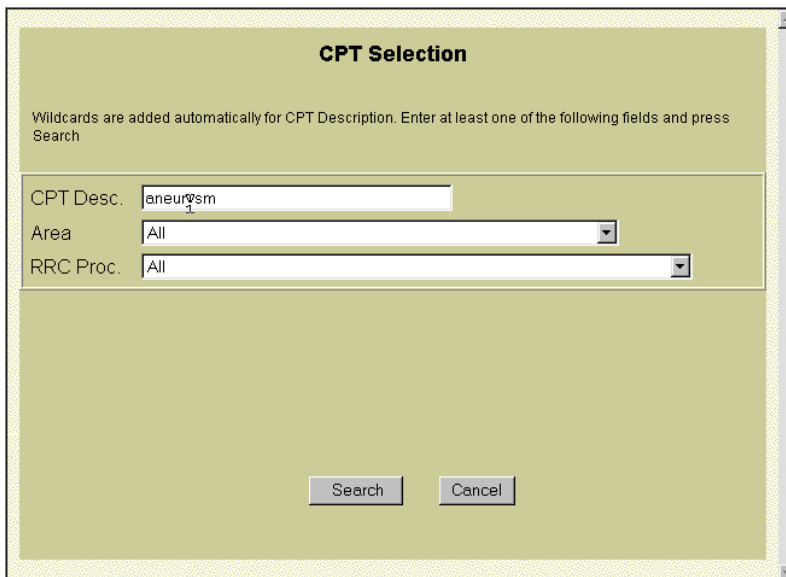
## Searching for a CPT Code

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



The screenshot shows a window titled "CPT Selection" with a light green background. At the top, it says "Wildcards are added automatically for CPT Description. Enter at least one of the following fields and press Search". Below this are three input fields: "CPT Desc." (a text box), "Area" (a dropdown menu set to "All"), and "RRC Proc." (a dropdown menu set to "All"). At the bottom of the window are two buttons: "Search" and "Cancel". A mouse cursor is visible over the "Search" button.

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 Desc." text box now contains the word "aneurysm". The "Area" and "RRC Proc." dropdown menus remain set to "All". The "Search" and "Cancel" buttons are still at the bottom.

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

<b>CPT Selection</b>	
<input type="button" value="Search Again"/> <input type="button" value="Cancel"/>	
*-indicates CPT is found in multiple area/types	
CPT	
01444Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm	<a href="#">select</a>
01652Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm	<a href="#">select</a>
35011Direct 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	<a href="#">select</a>
35001Direct 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	<a href="#">select</a>
35081Direct 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	<a href="#">select</a>
35102Direct 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	<a href="#">select</a>
35091Direct 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	<a href="#">select</a>
35141Direct 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)	<a href="#">select</a>
35121Direct 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	<a href="#">select</a>
35131Direct 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)	<a href="#">select</a>
35021Direct 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	<a href="#">select</a>
35161Direct 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	<a href="#">select</a>
35151Direct 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	<a href="#">select</a>
35045Direct 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	<a href="#">select</a>
35111Direct 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	<a href="#">select</a>
35005Direct 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	<a href="#">select</a>

View the list and choose the CPT code that closely or exactly reflects the procedure or 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 "aorta" 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 "aorta". 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 however you are only able to claim one for credit.**

To assist with data entry, the attending, institution, year in program, resident's role, patient type, rotation 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.

99292 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Area	Type
MISCELLANEOUS (NOT FOR MAJOR CREDIT)	OTHER PROCEDURES
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Ventilatory Management: >24hrs on ventilator
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Bleeding: non-trauma patient > 3 units
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Hemodynamic instability: req. inotrope/pressor
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Organ dysfunction: renal, hepatic, cardiac
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Dysrhythmias: requiring drug management
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Invasive line, manage/monitor: Swan, Arterial,etc
SURGICAL CRITICAL CARE PATIENT MANAGEMENT	Parenteral/enteral nutrition

The resident ultimately responsible for the patient should claim credit, and it should reflect the overall experience of the patients stay. If a procedure is performed, only one entry should be made for the patient. Enter the cpt code for the procedure and mark it for credit. Then on the same entry enter the critical care code(s) that apply. Even though the critical care codes are not marked for credit the system will count all critical care codes whether they are marked for credit or not.

The first type in the critical care list is for other procedures. This type should be used when the critical care patients treatment did not fall into any of the other critical care types.

1. Each resident will develop a log of at least twenty critical care patients who represent the broad scope of critical care index management. (NB: do not submit 20 of the same conditions)
2. Each of the patients listed in the log should include the management of at least 2 of the 7 categories listed below.
3. The completed logs should include experience, with at least one patient, in all seven of the categories (Within all 20 patients they should have had management within all seven categories).

Essentials in Critical Care Management Guidelines

Select the patients who best represent all the essential aspects of intensive care unit management. Each resident is to develop a Critical Care Index Case (CCIC) log of at least twenty patients who best represent the full breadth of critical care management. At least two out of the seven categories listed below should be applicable to each chosen patient. The completed CCIC log should include experience, with at least one patient, in all seven of the following essential categories:

Ventilatory Management	Central nervous system
Etiology/indications	Endocrine
Ventilatory modes/techniques	Hypothyroidism
Long term vs. short term intubation (days on the ventilator)	Adrenal insufficiency
Weaning method	Panhypopituitarism
	Diabetes insipidus
	SIADH
Bleeding (non-trauma) greater than 3 units necessitating transfusion/monitoring in ICU setting	Dysrhythmias
Etiology	Etiology
Coagulopathy:	Drug management
Hypothermia:	Therapeutic interventions
Autotransfusion:	Monitoring
Hemodynamic Instability	Invasive Line Management/Monitoring
Etiology	Arterial cannulation
Volume resuscitation	Pulmonary artery catheter
Inotropic/pressure support:	Physiologic profile – directed management
	Complications
	Nutrition
Organ Dysfunction/Failure (etiology/mode of management)	Route (parenteral/enteral)
Renal	Indications/contraindications
Hepatic	Solution formulation
	Complication

**CASE ENTRY FOR SURGERY GENERAL**

## Trauma Non-Operative – Guidelines

(multiple organ trauma no operation required) Required Minimum is 20  
Effective July 1, 2002

99199 Unlisted special service, procedure or report

Defined Categories: Trauma Non Operative  
Full CPT Code Desc: Unlisted special service, procedure or report  
Area: Patient Care (Not for Major Credit)  
RRC Procedure: Non-operative Trauma

Trauma Non-Operative is listed as not for major credit. This means you will not get credit as part of your total major operations but you will get credit for it being a defined category credit.

When entering the cpt code 99199 for non-operative trauma you can also enter critical care management if you were ultimately responsible for that patient. It should reflect the overall experience of the patients stay.

Guidelines include:

- 1) The category, major organ trauma, no operation required, refers to a patient with major organ trauma who was admitted to a critical care unit in the hospital, ie, SICU, CCU, Burn Unit, etc.
- 2) The most senior resident on the trauma service should claim credit for the MOTNOR case. In the instance where there is no trauma service, a fourth or fifth year general surgery resident may claim credit.
- 3) If the patient subsequently requires a general surgery operative procedure that may be claimed in the defined category "trauma, operative," then this case should not be recorded as MOTNOR.

## **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 a CPT code(s), only one can be marked for credit. 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. PDA software will be available for a \$25 user fee. Residents will be asked to sign a waiver at the initiation of data collection.