Case Log Information: Urogynecology and Reconstructive Pelvic Surgery

Review Committees for Obstetrics and Gynecology and Urology

The Review Committees have defined index categories required for fellow education in urogynecology and reconstructive pelvic surgery. The Review Committees use ACGME Case Logs to assess the breadth and depth of a program's procedural training as well as the individual fellow experience. This document provides information about the index categories, the minimum number of cases fellows are required to perform, and properly logging procedural experiences.

The index categories and minimums became effective beginning with the 2025 graduates. The Committees recognize that programs need to acclimate to the new required minimums, and so citations related to the minimums will not be issued at this time. Programs that do not meet minimum procedural requirements may receive an area for improvement (AFI).

Program directors are expected to monitor fellows' Case Logs to ensure that they are logging consistently and accurately. A list of urogynecology and reconstructive pelvic surgery tracked procedures can be found in the Accreditation Data System (ADS) > Case Log Tab > Reports > Tracked Codes Report. The column "Min Cat" indicates whether a procedure counts toward a minimum subcategory(ies). If a minimum subcategory is listed, credit is also given to the corresponding index category.

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Urogynecology and Reconstructive Pelvic Surgery
Minimum Numbers

Category	Minimum
Diagnostic Studies*	100
Complex urodynamics	25
Procedures for Urinary Incontinence	95
Stress Incontinence	65
Periurethral injection	5
Sling procedures	50
Urgency Incontinence	25
Sacral nerve modulation	10
Botox Injection	10
Surgery for Prolapse	130
Sacrocolpopexy	20
Colpocleisis	10
Vaginal colpopexy	40
Extraperitoneal	10
Intraperitoneal	10
Posterior repair	20
Surgery on Urinary System**	25
Urinary fistula repair	2
Urethral diverticulectomy	2
Ureteral stent placement	3
Retrograde pyelogram	1
Removal or revision of sling	5
Urethrolysis	0
Closure of cystotomy	1
Surgery on Genital System**	30
Vaginal hysterectomy	15
Lap hysterectomy (total and supracervical)	10
Revision/removal prosthetic vaginal graft	2
Surgery on Gastrointestinal System**	4
Repair of anal sphincter laceration	1
Rectovaginal fistula repair	1

*Batch logging available
**Surgeon + Assistant will be counted for all subcategories

Notes

- Minimum numbers represent what the Review Committees believe to be an acceptable minimal experience. Minimum numbers are not a final target number and achievement does not signify competence. Program directors must ensure that fellows continue to report their procedures in the Case Log System after minimums are achieved.
- Procedures given credit in an index subcategory are also given credit in the corresponding index category. For example, sling procedures are mapped to three minimum categories: sling procedures, stress incontinence, and procedures for urinary incontinence.
- Minimum counts include the roles of Surgeon and Teaching Assistant.

Surgeon, Assistant, and Teaching Assistant Roles

Surgeon
To be recorded as **Surgeon**, a fellow must perform at least 50 percent of the procedure, including a significant number of key portions. Two fellows may enter Surgeon for a bilateral procedure provided that they each complete one side, each is involved in 50 percent of the procedure, and each equally participates in key portions of the procedure.

Assistant
To be recorded as **Assistant**, a fellow must perform less than 50 percent of the procedure and/or not perform the key portions of the procedure.

Teaching Assistant
To be recorded as **Teaching Assistant**, a fellow directs and oversees major portions of the procedure being performed by a more junior fellow or a resident. The attending surgeon must function as an Assistant or Observer.

Questions

When are the urogynecology and reconstructive pelvic surgery procedural minimums effective?
The minimums are effective with the 2025 graduate cohort, i.e., fellows who complete the fellowship on June 30, 2025, or soon thereafter. Programs that do not meet minimum procedural requirements will not receive a citation but may receive an area for improvement (AFI).

How were the minimums determined?
Identification of minimums is a data-driven exercise based on graduate Case Log data. A subcommittee including members from the Review Committee for Obstetrics and Gynecology and the Review Committee for Urology reviewed all available graduate Case Log data from obstetrics and gynecology-based programs, urology-based programs, and all programs combined. Discussion of the minimum for each category/subcategory started with the 10th percentile of graduate experience representing a **minimum** threshold. This baseline is consistent with other (sub)specialties. To arrive at a final minimum number, subcommittee members reviewed the data in both obstetrics and gynecology-based programs and urology-based programs, and considered their knowledge and experience as subject matter experts.

When will programs start to be cited for not meeting the required procedural minimums?
The Committees recognize that it may take time for programs to acclimate to the new required minimums. Citations related to meeting the required procedural minimums will not be issued at least through the 2026 graduates.

Is it possible that the minimums may change in the near future?
There are no plans to update the minimum procedural requirements for at least a few years. Case Log data will be regularly reviewed. The Committees may consider revising the minimums once additional years of graduate Case Log data are available.

How should cystourethroscopies be logged?
Cystourethroscopies can be logged as a total for one day to reduce the burden of logging. To enter a daily total of procedures associated with a specific cystourethroscopy CPT code, fellows complete the required information for one patient (e.g., case ID, case date, attending), choose the correct cystourethroscopy CPT Code, enter the total number of procedures performed that day, and click “Add.” Cystourethroscopy CPT codes include 52000, 52001, 52005, 52204, and 52260.

How should fellows indicate that a procedure was performed robotically?
Procedures that can be performed robotically have a robotic checkbox on the CPT code description. Fellows should check the box when a procedure is performed robotically. The robotic checkbox provides fellows, programs, and the Committees with documentation regarding fellows’ robotic experiences.

How does the Case Log System determine which procedures count toward the laparoscopic/robotic minimum?
CPT codes for laparoscopic procedures automatically give credit toward the laparoscopic/robotic minimum. There is nothing additional a fellow must do.

Checking the robotic checkbox available on some CPT codes does not provide credit to the laparoscopic/robotic minimum. The robotic checkbox is there to differentiate laparoscopic from robotic experiences.

How should fellows indicate when a fascial sling is used?
Sling procedure CPT codes 51992, 57287, and 57288 have a fascial sling checkbox on the CPT code description. Fellows should check the box when a fascial sling is used.

How should fellows distinguish between a midurethral or pubovaginal sling?
Fellows should use CPT code 57288 and check the fascial sling checkbox, if appropriate. CPT code 20920 or 20922 should be added to the case if harvesting a fascia lata or rectus abdominis graft.

Which CPT code should be used for removal or revision of a vaginal sling?
Use CPT code 57287. Fellows should **not** use CPT code 57295, which is for revision/removal of prosthetic vaginal graft.

Are simple urodynamic tests being tracked in the Case Log System?
No. Simple urodynamic tests (CPT code 51725) are not being tracked and do not count toward the diagnostic studies minimum. While fellows are not required to log simple urodynamic tests, they may do so for their own purposes.

Can fellows log a complex urodynamic test if they only interpret the test?
No. To log the case in the Case Log System, fellows must perform and interpret the urodynamic test. Complex urodynamic test CPT codes that give credit toward the complex urodynamic minimum include 51726, 51727, 51728, 51729, 51741, 51785, and 51797.

Can fellows log anal ultrasound and anal manometry if they only interpret the test?
Yes. Fellows can log anal ultrasound (CPT code 76872) and anal manometry (CPT codes 91120 and 91122) if they perform and/or interpret the test.

Which procedures are considered a retropubic procedure and are mapped to that minimum?
Procedures considered a retropubic procedure and that are mapped to that minimum are Burch, laparoscopic Burch, and retropubic urethrolysis.

Do abdominal hysterectomies count toward the surgery on genital system minimum?
Yes. While abdominal hysterectomies do not have their own subcategory, the procedures do count toward the surgery on genital system minimum.

Which CPT codes should be used for sacral nerve modulation?
The following CPT codes can be used to log sacral nerve modulation: 64561, 64581, 64585, 64590, 64595, and 95972. Fellows should **not** use CPT codes 64553, 64555, 63688, 63661, or 63663.

Which CPT code should be used for urethrolysis for urinary retention (transvaginal, secondary, open) following a pubovaginal sling?
Use CPT code 53500.

Which CPT code should be used for cystourethroscopy with chemodenervation (Botox)?
Use CPT code 52287. Fellows should **not** use CPT code 90287 (equine botulinum toxin injection).

Why are there index subcategories with a minimum of zero?
The Review Committees identified several index subcategories that are important to monitor, but do not require a minimum experience. By including these subcategories in the list of minimum index categories, fellow experiences will be documented in the graduate Case Log reports.

Are there CPT codes that are tracked in the Case Log System but not mapped to a minimum?
Yes. Programs can find a list of tracked procedures in ADS > Case Log Tab > Reports > Tracked Codes Report. The column "Min Cat" indicates if a procedure counts toward a minimum subcategory/category.

If a resident and a fellow participate in a procedure, can both choose the Surgeon role?
A resident and fellow may each enter Surgeon for bilateral procedures, provided that each completes one side, each is involved in 50 percent of the procedure, and each equally participates in key portions of the procedure. **Note:** It is preferable for a fellow to serve as Teaching Assistant on resident-level procedures with the resident serving as Surgeon, and the attending surgeon functioning as Assistant or Observer.

A resident and fellow may also both log the Surgeon role for different aspects of a case with the resident serving as Surgeon on resident-level procedure(s) and the fellow serving as Surgeon the fellow-level procedure(s).

Can two residents log Surgeon and one fellow log Teaching Assistant for a single procedure?
This is acceptable only for bilateral procedures provided that each resident completes one side, is involved in 50 percent of the procedure, and equally participates in key portions of the procedure; the fellow directs and oversees the procedure; and the attending surgeon functions as Assistant or Observer.

Is it possible for a fellow to determine if a CPT code is mapped to a minimum category when entering a procedure in the Case Log System?
Yes. In the Case Log System, minimum subcategory(ies) are listed under the CPT Code description to the right of "Min Cat." While only subcategories are listed, credit is also given to the corresponding index category. For example, CPT code 57120 for colpocleisis (Le Fort type) lists the minimum subcategory colpocleisis. Colpocleisis is a subcategory of surgery for prolapse and credit is given to both colpocleisis and surgery for prolapse.

If "Min Cat" is not included under the CPT code description, the CPT code is not mapped to a minimum (sub)category.

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