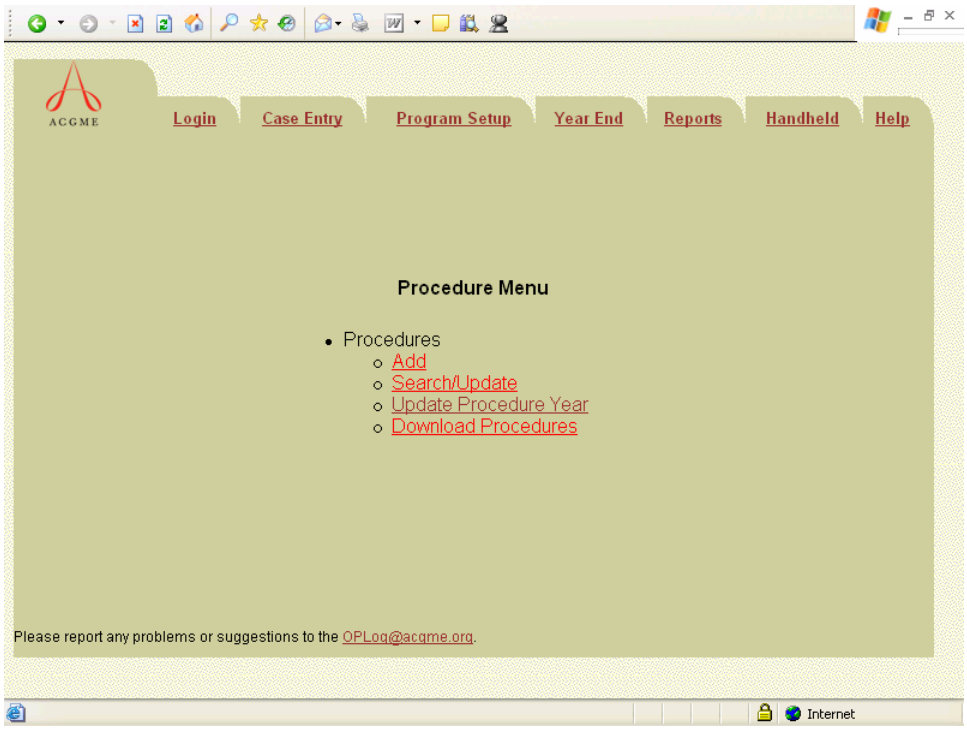
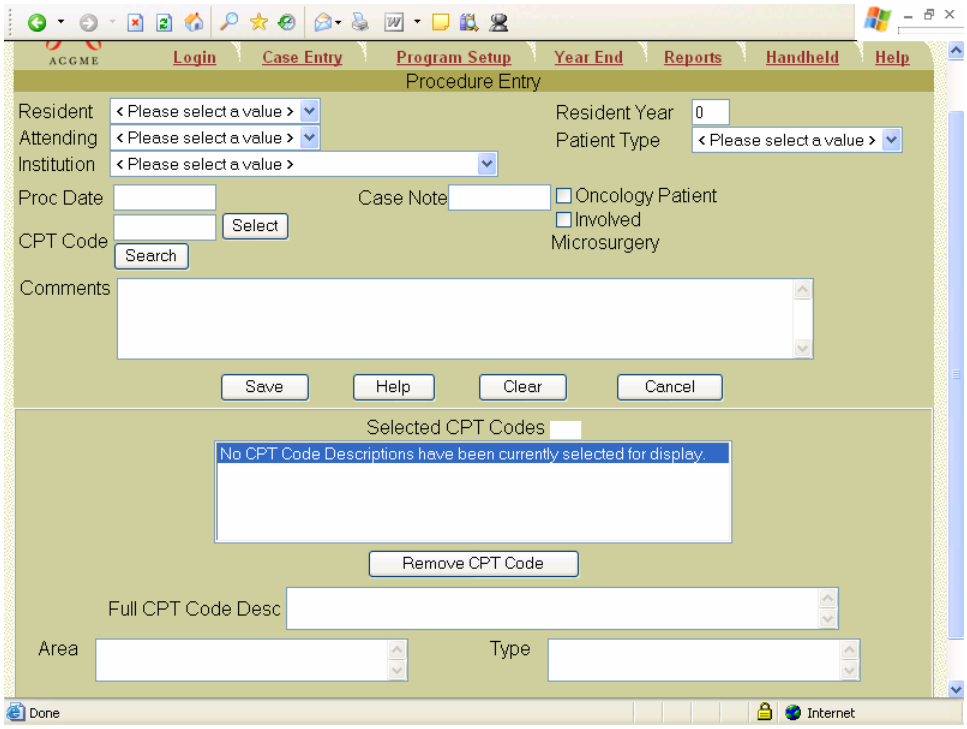
CASE ENTRY FOR ORTHOPAEDIC SURGERY AND ALL SUBSPECIALTIES

Click on the Case Entry tab and the Procedure Menu will display. To add new procedures, 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 ORTHOPAEDIC SURGERY AND ALL SUBSPECIALTIES

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 of the specialty (This is not your year in training) at the time of the case/encounter. Make sure the number in the Resident Year (PGY-2, 3, 4, or 5) is correct. (If you are in your first year, you should not be using the system.)The year will default to the year entered on the resident setup screen by your program director or residency coordinator
Patient Type:	Select Role using the down arrow. “

Adult:	Any patient 17 or older at the time of the procedure.
Pediatric:	Any patient younger than 17 at the time of the procedure.

Procedure Date:	Enter Date of procedure including / or – to separate month/day/year. Format mm/dd/yyyy.
Case Note:	Case Note 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.
Oncology Patient:	The procedure diagnosed or treated primary or metastatic, benign or malignant, bone or soft-tissue tumors.
Involved Microsurgery:	The procedure involved a microscope in the repair of a nerve or vessel
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. Enter up to six CPT Codes.
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.

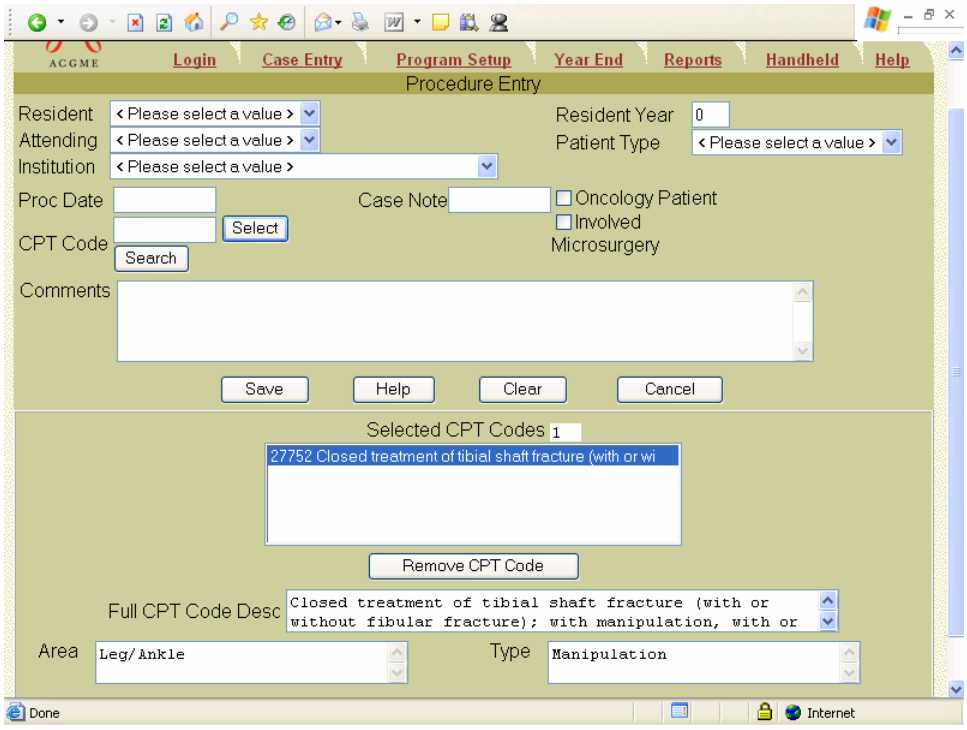
* If you are logging in as the administrator, you can click on the drop down box and choose the resident you are entering cases for.

Selecting a CPT code

For the procedure you are entering you will choose from the drop down list each of the following: attending, Institution and patient type. 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 the attending or Institution on your list you will need to contact your program director or coordinator to have them added to the list.

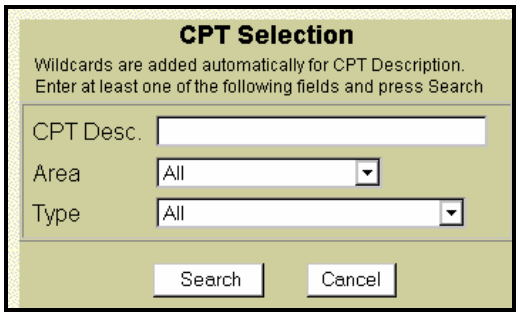
If you know the appropriate CPT code(s), in the CPT code field type the CPT code and click on the Select Button. The system will always move the CPT code from the field always leaving it blank and display it in the Selected CPT Codes List. In the pictured example, CPT code 27752. If the CPT code is valid it will automatically be placed in the "Selected Procedures" 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.

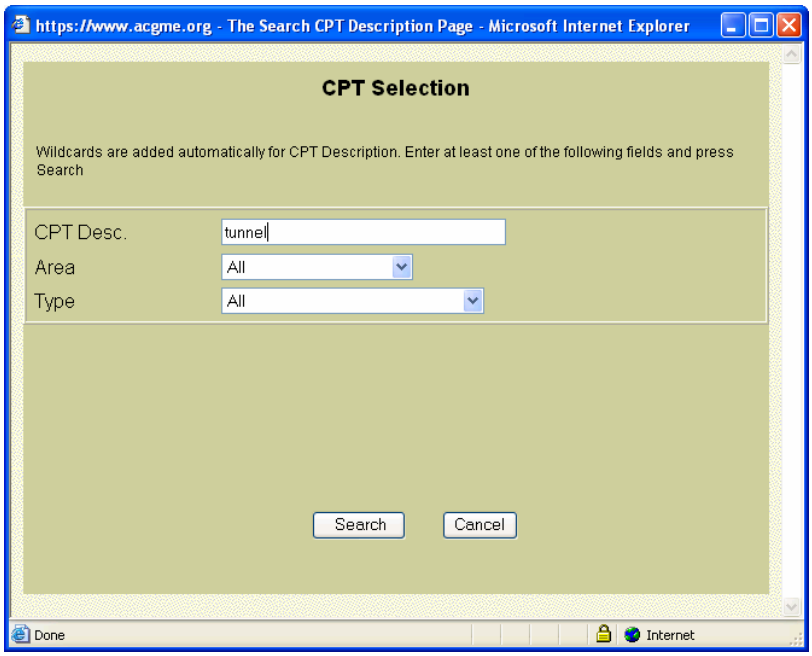
Search Function

To search for a CPT, click on the “Search” button next to the CPT code field. The “CPT Selection” window will display:

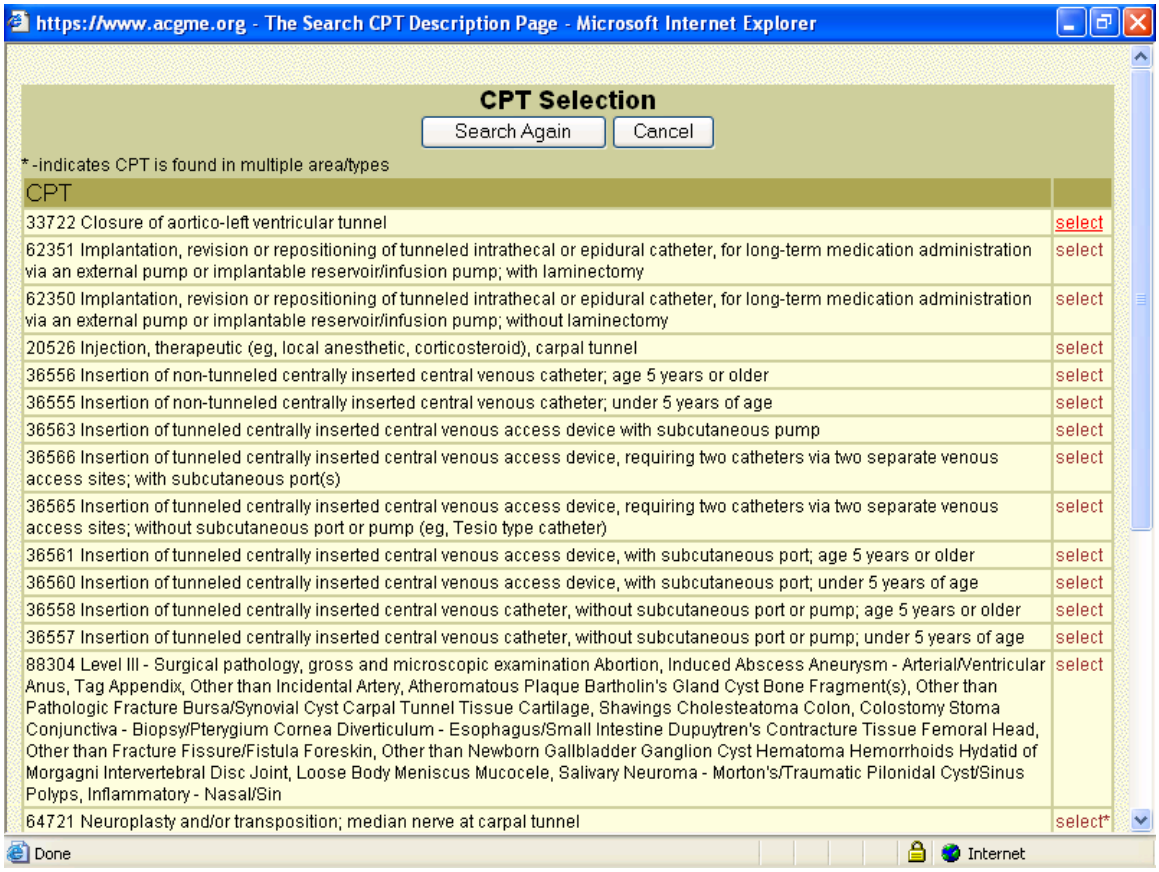


Note: Usual “Wildcard” searches (*, +, %, etc.) do not work with this function.)

CPT Selection allows the user to look for CPTs in multiple ways. A user can search for a specific phrase or word in the description. Or select an area and list all CPT descriptions available in the area. Or select an anatomic area and/or procedure from the drop-down boxes. Below is an example of entering a word or phrase that exists in the description:



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



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 “carpal” 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 “carpal”. 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 procedure up to five CPT Codes.

To assist with data entry, the attending, institution, year in program, 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.

What should be reported?

All Orthopaedic Surgery residents in their PGY-2 through PGY-5 years must report operative procedures **and manipulations** for which they were resident surgeons or assistants. Procedures which residents observe should not be reported. PGY-1 residents may (not must) use the system; if they do, they must be entered in the Orthopaedic Surgery (not General Surgery) Case Log System.

All operative procedures **and manipulations**, in the operating room, **emergency room**, or any other venue, must be reported. CPT Codes must be entered in accordance with the guidelines in the most recent *Complete Global Service Data for Orthopaedic Surgery* (published by the American Academy of Orthopaedic Surgeons) and most recent *Current Procedural Terminology* (published by the American Medical Association). Programs must provide residents with instruction regarding CPT coding as outlined in these two publications.

In rare circumstances, cases will involve more than five CPT Codes. For this system, however, the Committee has set a limit of five CPT Codes per anesthesia. Residents who perform such a procedure should select and report only five CPT Codes.

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, 2001. All patients should be entered with a CPT code(s) not to exceed six. 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.