

Colon and Rectal Surgery Case Log Instructions July 2011

Background

The ACGME Case Log System is a data depository which provides a mechanism that supports programs' efforts to comply with program requirements, and serves as a uniform method to verify the clinical education of residents among programs. The Case Log System is designed to capture and categorize a resident's experience with patient care. It was initially instituted in 2001, and the Review Committee for Colon and Rectal Surgery has required its use since 2005.

It is the intention of the Review Committee for Colon and Rectal Surgery that each resident has a reasonably equivalent educational experience to prepare them for practice of the specialty. As part of the process, the case numbers for each resident completing each ACGME-accredited program must be collected and analyzed. To accomplish this complex task, a structured database has been created using standard codes for diagnoses and procedures. The Case Log System for Colon and Rectal Surgery was designed to help programs and the Review Committee assess the breadth and depth of clinical experience provided to each colon and rectal surgery resident by their programs, and to create a real-time, on-going listing of residents' operative experiences so that their surgical education can be easily monitored and optimized, with the goal of improving the quality of all ACGME-accredited colon and rectal surgery programs.

The Review Committee would like to capture as many procedures and new patient encounters for each program as possible, in order to get a whole and accurate picture of each program and the educational experience it provides to residents. It is the responsibility of each individual resident to accurately enter his or her case data in a timely manner. The data entered will be monitored by program directors and analyzed by the Review Committee. Separate analysis reports are created annually for the Review Committee, for program directors, and for residents. Additionally, the ACGME provides information regarding individual residents' experience to the American Board of Colon and Rectal Surgery (ABCRS) as one of the criteria for admission to the ABCRS exam process.

.The system is HIPPA compliant, and agreements created by the ACGME are in place between the covered entities and the sponsoring institutions.

The Review Committee for Colon and Rectal Surgery recognizes that the Case Log System may not be perfect, and that it will continue to evolve. Comments and corrections are welcomed, and will be used to improve the system annually. **Feedback and questions can be sent to lking@acgme.org.**

Guidelines

- Both diagnoses and procedures are counted. They will be tallied separately.
- All acceptable ICD9 and CPT codes are listed on the spreadsheet. Do not use any other codes.
- The Review Committee is not currently tracking office visits or consults (E&M codes). However, all **new** diagnoses are needed to assess residents' exposure to the broad spectrum of colon and rectal surgery.
- Use the code that is closest to what was done. Not all ICD9 and CPT codes are available. Some have been altered to be more inclusive or to more clearly reflect current practice. Some have been entirely redefined to capture diagnoses or procedures not currently assigned a code, but which the Review Committee wishes to track. ***Pay close attention to the definitions in the spreadsheet, as they may not always exactly match those described online. All changes are highlighted on the spreadsheet.***
- Cases should be entered daily.

- Each case/encounter requires at least one diagnosis (ICD9) code and one procedure (CPT) code. If no procedure was performed, use the 99499 code for “No Procedure Performed.”
- Up to two diagnoses and two procedures may be entered per resident, per case, per day. Use the most important and acute diagnoses. Choose from among the applicable diagnoses and procedures to reach the minimum case numbers, as long as the codes chosen accurately describe what was done. (e.g., for a hemorrhoidectomy, fistulotomy, and abdominal rectal prolapse repair on the same patient on the same day, choose any two of the three procedures completed to code in the case logs).

A Case Form has been created within the spreadsheet; case details can be noted in the form, which can be printed out, for later entry.

It is to the resident’s advantage to accurately maintain and submit this information, which will describe his or her experience, as well as the program’s ability to provide this experience. If a resident does not complete this process, he or she may be deemed ineligible to enter the ABCRS certification process.

FAQs

What code should be used if the specific diagnosis or procedure is not on the list of codes available?

It is anticipated that the listed specific codes will cover over 95% of a resident’s experience. But there may be cases which are not described by any single code available. In such an instance, the case *can* be entered using a non-specific code ending in 99 with a text description. However, it is best to choose a code for a diagnosis or procedure as close as possible to that which was done, rather than to use a 99 code, since the latter will not count toward a required case category.

Which diagnosis or procedure codes should be used if more than two are applicable for a case?

The available code for the diagnosis or procedure of the highest complexity should be used first. If the applicable codes include any diagnoses or procedures the resident needs to meet requirements, and those were done along with others perhaps of higher complexity, the codes for the portion of the operation needed most to meet the requirements may be used. Note that at this time, only two diagnoses and two procedures may be entered per resident per case per day.

Can new diagnoses for follow-up patients be entered?

For non-procedural visits, a resident can only enter encounters for patients never seen before (New), or follow-up patients with new problems not previously managed by the resident, even if seen by a colleague (Establish – New problem).

Established/follow-up/post-operative patient visits cannot be counted for a patient already seen by the resident for the same problem.

Example:

A resident sees a patient with Crohn’s disease of the terminal ileum in the clinic. No procedure is performed. The patient is scheduled for ileocolic resection. The resident can enter that patient as:

- 555.0 – Crohn’s disease, small intestine
- 99499 – No Procedure Performed

The same patient undergoes elective resection the following week. The resident enters:

- 555.0 – Crohn’s disease, small intestine
- 44160 – Ileocolic resection

The resident sees the patient for a post-operative visit six weeks later. No procedure is performed. No entry.

The patient returns two months later with a new perirectal abscess which the resident drains in the ER. The resident enters:

- 566 – Perirectal abscess
- 46040 – Drainage of perirectal abscess

What CPT code should be used when a new patient is seen but no specific procedure is performed on that day?

99499 E&M – No procedure/visit only – This code should be used when no procedure is performed, as with a New Patient Visit or a Hospital Consult. If any coded procedure is performed on the same day, such as an anoscopy, or if the patient is taken to the operating room, that procedure code should be used alone; it is not necessary to add the 99499 code.

If a resident operates on a patient and then sees the patient in follow-up, the follow-up cannot be counted as a new diagnostic (Dx) encounter. If a resident sees a patient for a follow-up visit, but has not yet cared for the patient, then the visit can be counted. The Dx can only be counted once per patient. Additional diagnoses can be counted for existing patients, but only once per diagnosis.

What does “Separate Procedure” mean in a CPT code?

When “Separate Procedure” is specified in the CPT description, the code cannot be used with any other related code.

Examples:

- “44005-Enterolysis/lysis of adhesions (separate procedure) with a colectomy code such as 44140-Colectomy, partial” cannot be used with anastomosis, even if the lysis of adhesions (LOA) is extensive, because the LOA is part of the primary procedure.
- “44005-Enterolysis/lysis of adhesions (separate procedure)” is used alone when operating for an adhesive small bowel obstruction (ICD9: 560.81- Intestinal or peritoneal adhesions with obstruction).

How should laparoscopic cases that are converted to open laparotomy be coded?

Laparoscopic cases that are converted to open may be coded as a laparoscopic case if more than just an exploration and some lysis of adhesions were performed prior to opening. Otherwise, they should be coded as the relevant open case.

How are stomas counted?

Stomas are counted independently, in addition to any other procedure.

Stomas are included in many codes; these will automatically be added to the stoma count in the reports. If a stoma is not explicitly included in the primary CPT code (e.g., 45110 APR, or 44146 LAR with ostomy) a stoma code may be added when the stoma is performed as the second CPT code, so that the resident will get credit for the stoma. The guidelines for most procedures are listed in the column labeled “Stoma included?” in the CPT pages.

Which cases can be split into two codes?

When two parts of a procedure are clearly separate, they may be reported separately.

Examples and Clarifications:

- Separate anorectal and abdominal procedures performed at the same time – a hemorrhoidectomy and a laparoscopic ventral hernia repair.
- A small bowel resection and a low anterior resection, even if both are for Crohn’s disease.

- A small bowel resection can only be reported with a right colon resection if it is a separate segment, not the attached ileum.
- An ostomy, if not a routine part of the procedure (i.e., included in the CPT description of the procedure). If it is included in the CPT code, it will automatically be counted (e.g., 45110 APR, 44146 LAR with ostomy).
- An intra-operative endoscopic procedure of any kind (e.g. proctoscopy prior to an LAR, an intra-operative colonoscopy to localize a colon lesion not seen during laparoscopy).

However, in general, when a single listed code well describes a procedure, it cannot be split.

Examples and Clarifications:

- 44146 – Low anterior resection with anastomosis and proximal ostomy. An individual resident cannot split the colostomy portion off and use 44146 and 44310.
- A segmental colectomy cannot be reported with a total colectomy.
- A hemorrhoidectomy cannot be split, no matter how many columns are removed.
- A hemorrhoidectomy cannot be reported with skin tag or papilla excision since they are considered part of the procedure.
- Internal and external hemorrhoids cannot be reported separately.

Can a second resident count a stoma or other procedure when the main procedure was performed by another resident?

Yes, if the first resident did the main procedure, such as a low anterior resection, and then the second resident scrubs in to create a loop ileostomy. The first resident would have to code for an LAR alone (44145, and not 44146 which includes a stoma) and the second resident can then code for an ileostomy (44310). A procedure that always requires an ostomy such as a Hartmann’s procedure or an APR, cannot be split this way.

Similarly, a second resident may come into the operating room to perform an intra-operative colonoscopy to localize a colon lesion not seen during attempted laparoscopic resection, and can then log that procedure.

How will the codes entered be correlated with the minimum case numbers?

Each code will be mapped to one or more case categories. All of those that satisfy a required minimum case number will automatically map to that category and be counted toward the resident’s minimum numbers.

Many cases will show up on the Case Log Report in several places. For example, a laparoscopic low anterior resection with loop ileostomy (44208) will be counted as a Low anterior resection, a Laparoscopic case, a Pelvic dissection, and a Stoma creation.

Can cases performed during general surgery education be counted?

No. The data collected in the Colon and Rectal Surgery Case Log is completely separate from that collected during a resident’s general surgery residency education. Only cases performed during the 12 months of the Colon and Rectal Surgery residency, and as part of the program at approved sites, may be entered. No cases are carried over.

The system relies on the honest efforts of each resident to enter his or her experience to the best of his or her ability. Program directors monitor the logs and will be able to detect any irregularities. Additionally, each resident’s log as well as each program’s total collective logs are annually monitored by the Review Committee.

Fields

Resident: Resident name

Attending:	Attending Physician name. This must be one of the program attending identified in the ACGME system. Ask the program director for a list.
Institution:	Select the Institution where the case/encounter was performed.
Resident Year:	2011-2012
Resident Role:	Select the Role from the drop-down list: Surgeon or Teaching Assistant
Date:	Enter Date of case/encounter (Format: mm/dd/yyyy).
Case ID:	A unique identifier for the individual patient, typically, his or her medical record number.
Code:	Use the ICD9 and CPT codes in the spreadsheet. In the online system, there are search capabilities and drop-down menus to help locate the appropriate and available codes. The Review Committee 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 "Miscellaneous" category.
Full Code Desc.	Online version only. This is the full CPT/ICD9 description. This field is populated by the database based on the CPT/ICD9 code chosen.
Area:	Online version only. The area represents the broadest category of procedure/diagnosis the Review Committee is tracking.
Type:	Online version only. This is the more specific procedure/diagnosis category that the Review Committee is tracking.
Comment:	This can be notes about the patient and/or procedure. This is not a mandatory field.

Glossary

AP	Combined abdomino-perineal approach
APR	Abdomino-perineal resection
CAA	Colo-anal anastomosis
CPT	Current procedural terminology
HIPEC	Hyperthermic intraperitoneal chemotherapy and cytoreduction
IAA	Ileo-anal anastomosis
ICD-9	International classification of disease, version 9
IPAA	Ileal pouch-anal anastomosis, restorative proctocolectomy
IRA	Ileo-rectal anastomosis
LAR	Low anterior resection
NEC	Not elsewhere classified
NOS	Not otherwise specified. Code used when a more specific code is not available.
TPC	Total proctocolectomy