

MEMORANDUM

TO: Urology Program Directors

FROM: Louise King
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Members, Review Committee for Urology

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RE: Resident Surgical Index Case List Redefined For 2009:
Recommended Minimum Numbers and Core Domains Emphasized

The Urology Residency Review Committee (RRC) will implement a new system for evaluating resident surgical experience based on “recommended minimum numbers.” Beginning July 1, 2009, graduating resident index procedure case logs will be reported side-by-side with the newly established recommended minimum numbers for urology residency education. A series of other important changes in surgical case log entry are forthcoming in what the Committee hopes will be welcome news for urology residents and program directors nationwide.

The new recommended minimums will reflect the lowest acceptable clinical volume of critical procedures performed per resident for program accreditation. The recommended minimum number levels have been set near the tenth percentile, a level traditionally used by the RRC to trigger program citations for providing inadequate surgical experience. A program complies with requirements if each resident in the program achieves the minimum number of procedures for each listed procedure or category.

Surgical procedure case logs for graduating residents will also be reported categorically, organized into “core domains” as follows:

- general urology
- endourology/stone disease
- laparoscopic surgery
- reconstructive surgery
- oncology
- pediatric urology (minor and major)

In reporting resident experience by the new core domains, broad categories of surgical activity will be assessed, thus ensuring a diverse educational exposure. Within each category, however, certain specific critical procedures (or sub-categories of procedures) will also be monitored. Residents will continue to enter all surgical activity during training. Program directors should ensure that reporting

of surgical training does not end once minimum numbers are achieved by a resident—these numbers do not constitute a final target number, but rather reflect what the Urology RRC believes is merely an acceptable minimal exposure during residency.

Benefits of Establishing Recommended Minimum Numbers and Core Domains for Assessment of Resident Surgical Experience:

1. Simplification: Reported numbers of procedures have varied greatly over the past decade. Citations for inadequate specific case types (e.g., TURP or SWL) do not take into account changing practice patterns, such as increased use of medical or minimally invasive treatments for BPH and increased use of flexible ureteroscopy and laser lithotripsy for ureteral stones. The new system will establish fixed targets for reasonable minimum exposure levels that program directors can reliably use to guide and assess resident involvement in surgical procedures.
2. Fewer citations: Inadequate procedural experience has long been the most common program citation rendered by the Urology RRC, typically generated when a reported index case falls below the 10th percentile. The new system establishes cut points near the 10th percentile for each specific listed procedure and better reflects activity in important related types of procedures.
3. Flexibility and subspecialization encouraged: The committee acknowledges that fellowship training may be an important element in attaining subspecialty expertise in various core domains of urology. By establishing recommended minimum numbers for resident activity, the committee encourages broad exposure to a wide array of procedures for all residents during training. Once a senior resident attains the various recommended minimum numbers of cases, program directors will have the flexibility to provide further emphasis on an elective basis in specific core domains of interest.
4. Citations easier to remedy: Deficiencies in a core domain (e.g., Oncology) are more meaningful than deficiencies in a specific procedure (e.g., RPLND, adrenalectomy), which may not be commonly performed nor easily increased. The need for new clinical rotations or faculty recruitments can be identified more readily to remedy deficient core domains.
5. Competency-based education emphasized: Resident index case logs are one representation of the “Patient Care” competency which, along with the five other ACGME Core Competencies, comprise the basis for accreditation of graduate medical education nationwide. The committee encourages increasing implementation of competency-based education in all six areas.

Other Changes:

1. Definition of Surgeon for Case Entry: Resident participation in a surgical procedure will be credited as an index case whether they function as “surgeon” or “first assistant.” To be recorded, a resident must be present for all of the critical portions of the case and must perform a significant

number of the critical steps of the procedure. It is expected that over the course of their training, residents will develop the skills necessary to perform progressively greater proportions of complex cases and will be given the opportunity to demonstrate those technical skills to program faculty; performance of an arbitrary percentage of the steps (i.e., 50%) is no longer a criterion to record resident involvement as surgeon. Involvement in preoperative assessment and postoperative management of patients is still considered to be an important element of resident participation.

2. Assistant Surgeon: In general, only one resident should record any procedure for credit—activity as “second assistant” should not be recorded. Although it is expected that junior residents will observe and/or assist frequently prior to acting as primary surgeon or first assistant, this activity will no longer be specifically tracked in the case logs.
3. Teaching Assistant: “Teaching assistant” activity is felt to have significant educational value and will now be recognized for index case credit. When a chief or senior resident acts as a teaching assistant, directing and overseeing major portions of the case while the supervising attending staff functions as an assistant or observer, a second resident may then also record the case for credit as “surgeon”.
4. Adult Cystoscopy: Cystoscopy in adult patients will no longer be considered an index case and thus will no longer need to be entered into the ACGME case logs. Importantly, cystoscopy in pediatric patients will continue to be tracked as an index case.
5. Urodynamics: Residents will now be expected to participate in and interpret at least 10 urodynamic studies, and this activity must be entered into the case logs.
6. Transurethral resection: Includes transurethral bladder and prostate cases.
7. Reconstruction: Includes prosthetics, ureteral, urethral and genital reconstructions, and repairs of traumatic injuries.
8. Pediatric Urology: Surgical procedures performed on children will now be defined as “major” and “minor”. Endoscopic, scrotal, and inguinal cases on children will now be listed as “minor” cases. Hypospadias and ureteral surgery (i.e., pyeloplasty, reimplant) will now be listed as major procedures. Other specific types of major pediatric procedures (e.g., nephrectomy, bladder augmentation) will be counted toward the “pediatric major” total rather than listed individually.

Unbundling: In an effort to simplify the case recording process, the Urology RRC seeks to model the data capture for case logs in a manner similar to the method used for billing. If multiple related procedures are performed on the same patient, (e.g., radical cystoprostatectomy, pelvic lymphadenectomy, ileal conduit), only one code should be entered. If multiple unrelated procedures are performed on the same patient (e.g., nephrectomy and prostatectomy) each may be captured by the resident and two procedure codes may be entered. If two residents each do one side of a bilateral procedure, each resident may record the procedure as surgeon.

Statement of Intent:

Achievement of the minimum number of listed procedures does not signify achievement of competence of an individual resident in a particular listed procedure. A resident may need to perform an additional number of listed procedures before they are deemed competent in each procedure by the program director. Moreover, the listed procedures represent only a fraction of the total operative experience expected of a resident within the designated program length. The intent is to establish a minimum number of listed procedures for accreditation purposes, without detracting from the latitude that the program director must have to determine the entire educational operative experience for each resident, taking into account each resident's particular abilities.

This requirement does not supplant the requirement that, upon the resident's completion of the program, the program director should verify that the resident has demonstrated sufficient professional ability to practice competently and without direct supervision.

**Urology RRC Revised Index Categories & Procedures
Required Minimum Numbers (December 2008)**

Index Category	Required Minimum Number
ADULT UROLOGY	
General Urology	200
Transurethral resection	100
Transrectal ultrasound-guided prostate biopsy	25
Scrotal/inguinal surgery	40
Urodynamics (participate and interpret)	10
Endourology/Stone Disease	100
Shock wave lithotripsy	10
Ureteroscopy	40
Percutaneous renal procedures	10
Laparoscopy	20
Reconstruction	60
Male	15
<i>Penile/incontinence</i>	10
<i>Urethra</i>	5
Female	15
Intestinal diversion	8
Oncology	100
Pelvic	40
<i>Prostate</i>	25
<i>Bladder</i>	8
Retroperitoneal	40
<i>Kidney</i>	30
PEDIATRIC UROLOGY	
Minor	30
Endoscopy	5
Hydrocele/hernia	10
Orchiopexy	10
Major	15
Hypospadias	5
Ureter	5

Individual CPT codes are indexed into each applicable category and sub-category. For example, CPT 51797 contributes one case towards the requirements for general urology and urodynamics and CPT 51596 contributes to oncology, pelvic, bladder, reconstruction, and intestinal diversion.

Index Categories, Minimum Numbers, and Common CPT Codes for Urology Residents

(Prepared by ACGME Residency Review Committee for Urology)

	Min	Common CPT codes
ADULT UROLOGY		
General Urology	200	
Transurethral resection	100	52224 (bladder bx); 52234,25,40 (TURBT s/m/l); 52601 (TURP); 52648 (PVP)
TRUS/prostate biopsy	25	55700 (and 76872 for TRUS)
Scrotal/inguinal surgery	40	54530 (inguinal orchiectomy); 55040 (hydrocelec); 55250 (vasectomy); 55400 (vaso-vaso); 54900 (vaso-epi); 55530 (varicocele ligation)
Urodynamics (participate and interpret)	10	51797
Endourology/Stone Disease	100	
Shock wave lithotripsy	10	50590
Ureteroscopy	40	52344 (stricture); 52345 (UPJ obstruction); 52352 (stone removal); 52353 (laser); 52354 (tumor bx); 52355 (resection)
Percutaneous renal	10	50080 (<2cm); 50081 (>2cm); perc cryo (50593)
Laparoscopy	20	automatically counted
Reconstruction	60	50544 (lap pyeloplasty); 50780 (reimplant)
Male	15	
<i>Penile/incontinence</i>	10	54360 (plication); 54405 (IPP); 54440 (penile fx); 53440 (male sling); 53445 (AUS)
<i>Urethra</i>	5	53410 (urethroplasty); 53215 (urethrectomy)
Female	15	57288 (sling); 57260 (AP repair); 53500 (urethrolysis); 53230 (diverticulectomy); 57320 (VVF repair)
Intestinal diversion	8	automatically counted with cystectomy; otherwise use 50820 (ileal conduit); 51960 (augment); etc.
Oncology	100	
Pelvic	40	
<i>Prostate</i>	25	55866 (lap/robot RP); 55840/55842/55845 (RRP with no/limited/extended PLND)
<i>Bladder</i>	8	51595 (RC/conduit); 51596 (RC/continent diversion); 51597 (pelvic exent); 51550 (partial cx)
Retroperitoneal	40	38780 (RPLND); 60650 (lap Ax); 60540 (open Ax)
<i>Kidney</i>	30	50230 (ORN); 50240 (OPN); 50542 (lap tumor ablation); 50543 (LPN); 50545 (LRN); 50547 (lap donor); 50548 (lap NU)
PEDIATRIC UROLOGY		
Minor	30	
Endoscopy	5	52000 (cysto); 52005 (RPG); 52300

	Min	Common CPT codes
		(ureterocele); 52327 (sting); 52332 (stent); 52400 (PUV); any ureteroscopy (see adult list)
Hydrocele/hernia	10	49496 (<6m); 49500 (6m-5y); 49505 (>5y)
Orchiopexy	10	54640/50/92 (orchiopexy via ing/abd/lap); 54600 (fixation for torsion)
Major	15	50220 (total Nx); 50240 (partial Nx); 50400 (pyeloplasty); 50845 (appendicoves)
Hypospadias	5	54322 (distal); 54324 (distal with flap); 54332 (prox)
Ureter	5	50780 (reimplant); 50782 (duplicated)

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