



## **Colon and Rectal Surgery Case Log Instructions Review Committee for Colon and Rectal Surgery**

### **Background**

The ACGME Case Log System is a data depository which provides a mechanism that supports programs in complying with requirements, and also provides a uniform mechanism 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 by accredited programs 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 for the practice of the specialty. As part of the process, the case numbers for each resident completing a program are 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 helps assess the breadth and depth of clinical experience provided to each colon and rectal surgery resident by his or her program with the ultimate goal of improving the programs themselves.

It is the responsibility of the individual residents to accurately and in a timely manner enter their case data. The data entered will be monitored by the program directors and analyzed by the Review Committee. Separate analysis reports are created annually for the 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 criterion for their admission to the ABCRS's exam process.

The Review Committee seeks to capture as many procedures and new patient encounters as possible to help understand the residents' experience and monitor the quality of education for each program. The goal is to create a real-time, ongoing listing of residents' operative experiences so that surgical education can be easily monitored and optimized.

The Case Log System is HIPPA-compliant, and there are agreements, created by the ACGME, in place between the covered entities and the sponsoring institutions.

The Review Committee for Colon and Rectal Surgery recognizes that the Case Log System is not perfect, and that it will continue to evolve. We welcome comments and suggestions for improvement.

## Guidelines

All CPT and ICD9 codes used in the ACGME Case Log System for Colon and Rectal Surgery are listed in the “Tracked Procedures for Specialty by Category” report that may be obtained via the “Reports” menu within the system itself. Run the report using all default settings to see the assigned defined case category for each CPT/ICD9 code.

- Both diagnoses and procedures are counted. They will be tallied separately.
- All acceptable ICD9 and CPT codes are listed. 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 encompassing or to more clearly reflect current practice. A few have been entirely redefined to capture colon and rectal surgery diagnoses/procedures not currently assigned a code, but which the Review Committee wishes to track. ***Pay close attention to the descriptions in the tracked procedures report as they may not match the ones in official coding books.*** This is a work-around since we are limited to the existing codes.
- Residents should enter cases 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. Residents may choose among applicable diagnoses and procedures to reach the minimum case numbers as long as the codes accurately describe what was done. For example, if a resident did a hemorrhoidectomy, fistulotomy, and abdominal rectal prolapse repair on the same patient on the same day, he or she may choose any two of the three to code.
- Each case requires the resident to select one of three participation levels:
  - Surgeon: The resident must be present for the majority of the procedure and must perform the key or critical portions of the procedure under faculty supervision.
  - Assistant: The resident must be present for the majority of the procedure and must act as the first assistant to the faculty member or resident surgeon performing the procedure. Only one resident may claim this role per case. The Review Committee recognizes that first-assisting at operations is an important part of resident experience, particularly in complex or relatively uncommon cases.
  - Teaching Surgeon: The resident must guide a more junior resident through a procedure in which the junior resident performs the key or critical portions of the procedure. The faculty surgeon acts as an assistant or observer as appropriate.

All participation levels count toward meeting the required minimum numbers in each defined case category. The Review Committee will monitor the reported participation levels as an indicator of progressive responsibility.

**It is to the resident’s (and the program’s) advantage to accurately maintain and submit this information, as it will describe the resident experience and the program’s ability to provide this experience. If a resident does not complete this process, he or she may not be deemed eligible to enter the ABCRS certifying process.**

## FREQUENTLY ASKED QUESTIONS

### ***Which codes should be used for case entry?***

Only the codes listed in the case log report “Tracked Procedures for Specialty by Category” should be used. Only cases using the defined codes will be counted toward a resident’s case volume.

The Case Log System uses diagnosis (ICD9) and procedure (CPT) codes that were developed by the American Medical Association (AMA). These codes are commonly used for billing purposes by billers and insurers, and so are fairly detailed. Often the detail and specificity of these codes is more than is needed by the Review Committee; on the other hand, there are many procedures commonly performed which are not specifically described by CPT codes. Therefore, some codes have been altered to be more encompassing or to more clearly reflect current practice. A few have been completely changed to capture colon and rectal surgery diagnoses/procedures not currently assigned a code, but which the Review Committee wishes to track.

Examples:

- Some groups of codes have been simplified, e.g., all perirectal abscess I&Ds have been put into one code; all open ventral/incisional hernia repairs were put in one code
- Some bundled anorectal codes have been eliminated, e.g., “Hemorrhoidectomy with fistulotomy” is not used; two separate codes (“Hemorrhoidectomy” and “Fistulotomy” should be used.
- Some codes have been made more specific, e.g., “596.0 – Other anorectal polyps,” has been changed to “Hypertrophied Anal Papilla.”
- A few codes have been completely changed, e.g., “44045 – Abscess drainage...” has been changed to “Fistulotomy, LIFT procedure.”
- Special changes to note:
  - 211.9 – FAP – Familial adenomatous polyposis and related APC syndromes
  - V18.51 – Inherited polyposis syndromes including HNPCC (Other than FAP)

### ***What code should be used if the specific diagnosis or procedure is not on the list?***

The list of codes is not meant to be all-encompassing. There will be cases which are not described by any code available. These may be entered using a non-specific code ending in “99,” with a text description. However, it is best to choose a code as close to what was done as possible rather than to use a “99” code, since the latter will not count toward a required case category. It is anticipated that the listed specific codes will cover over 95 percent of a resident’s experience.

### ***If more than two diagnoses or procedure codes are applicable, which should be used?***

Generally, it is advisable to use the highest complexity code possible. However, if a resident needs more of a particular type of procedure, and such a procedure was done among several others, he or she may use the codes for the portion of the operation that is needed to meet minimum requirements. At this time, only two diagnoses and two procedures may be entered per resident per case per day.

### ***When can new diagnoses for patients be entered?***

When entering procedures, at least one diagnosis (ICD9) must be entered for each procedure or set of procedures (CPT). There may be 1 ICD9 and 1 CPT, 1 ICD9 and 2 CPTs, or 2 ICD9s and 1 CPT.

When seeing a patient for a non-procedural visit, only enter an encounter for a patient never seen before (New) or for a follow-up patient with a new problem not previously managed by the resident (even if seen by a colleague) (Established – New problem).

A resident cannot count established/follow-up/post-operative patient visits for a patient already seen with the same problem.

Example: The resident sees a patient with Crohn’s disease of the terminal ileum in the clinic. No procedure is performed. He is scheduled for ileocolic resection. The patient can be entered 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 same patient returns two months later with a new perirectal abscess which the same resident drains in the ER. The resident enters:

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

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

99499 E&M – No procedure/visit only – Use this code 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 OR, use that procedure code alone. It is not necessary to add the 99499 code.

If a resident operates on a patient and then sees him or her in follow-up, the follow-up cannot be counted as a new dx encounter. On the other hand, if the resident sees a patient for a follow-up visit, but has not previously cared for him or her, then the visit can be counted. The dx can only be counted once per patient. Additional diagnoses in existing patients can be counted, 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. For example, 44005-Enterolysis/lysis of adhesions (separate procedure) cannot be used with a colectomy code such as 44140-Colectomy, partial; or with anastomosis, even if the lysis of adhesions 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?***

A laparoscopic case that is converted to open may be coded as a laparoscopic case if more than just an exploration and some lysis of adhesions was performed prior to opening. Otherwise, it 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 (e.g., 45110 APR, or 44146 LAR with ostomy). These are shown in the defined category column of the Tracked Procedures report, and will automatically be added to the stoma count in the reports.

If a stoma is not explicitly included in the primary CPT code, a stoma code can be added when 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?***

Generally, whenever a single listed code fully describes a procedure, it cannot be split.

Examples:

- 44146 – Low anterior resection with anastomosis and proximal ostomy. An individual resident cannot split the colostomy portion off and use 44146 and 44310. It would not be to the resident's

advantage anyway, since the procedure maps to the LAR and to a colostomy already, and credit can only be received for the diagnosis once per patient per day.

- A segmental colectomy cannot be reported with a total colectomy.
- A hemorrhoidectomy cannot be split, no matter how many columns are removed.
- A resident cannot report a hemorrhoidectomy with skin tag or papilla excision since these are considered part of the procedure.
- Internal and external hemorrhoids cannot be reported separately.

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

Examples:

- Separate anorectal and abdominal procedure 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, can be separated.
- 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 (e.g., included in the CPT description of the procedure), can be separated. 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), can be separated.

***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 could 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 OR to perform an intra-operative colonoscopy to localize a colon lesion not seen during attempted laparoscopic resection.

***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 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 Tracked Procedures 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 residency be counted?***

The data collected in the Case Log System for Colon and Rectal Surgery is completely separate from that collected during a general surgery residency. 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. The Honor Code is in effect, as always. Program directors monitor the logs regularly, and will be able to detect any irregularities. Additionally, each resident's log, as well as the each program's total log, are annually monitored by the Review Committee.

***Which codes count toward fulfilling the ABCRS "Zero Case Rule" for Incontinence Surgery?***

The following sphincteroplasty codes fulfill this Board requirement: 46750, 46753, 46754, 46760, 46761, 46762, 51715, and 64581.

### ***What are the Review Committee's expectations for monitoring resident case logs?***

Programs must monitor the accurate and timely entry of cases into the system. As part of monitoring resident progress towards developing competence in surgical skills, cumulative operative experience reports should be generated from the Case Log System and reviewed with each resident as part of his or her semiannual review. More frequent monitoring and feedback is highly recommended.

A variety of case log reports are available in the system; each providing useful information for monitoring.

- **Code Summary Report**  
This report provides the number of times each CPT code is entered into the Case Log System by the program's residents. Filtering by specific CPT code, attending, institution, and/or setting can provide useful information on surgical activity in the program that might, for example, be used to make targeted changes in rotation schedules, curriculum, faculty assignments, etc. This report can also be especially helpful in monitoring the procedures that do not count towards the minimums. Choosing non-tracked codes on the area dropdown will show the CPT codes that have been entered and will not count on the minimums report. These codes can be easily reviewed to determine if the resident miscoded something that should be adjusted or it really was a minor procedure that doesn't fit into the Review Committee minimums.
- **Minimums Report**  
To track resident progress toward achieving minimum numbers, a separate report should be generated for each resident using the default settings.
- **Resident Activity Report**  
This is a summary report that provides total number of cases, total number of CPT codes, most recent procedure date and last time an update was made for each resident or for the selected resident. This report is a quick way to keep tabs on how frequently residents are entering their cases. For example, if the program requires residents to enter cases each week, the report can be run weekly; a resident that has not entered a case within the past week would be quickly identified.
- **Resident Brief Report**  
The brief report lists the procedure date, case ID, CPT code, institution, resident role, attending, and description for each case for each selected resident.
- **Resident Experience Report by Role**  
This report lists all procedures, including those that do not count toward the required minimum numbers, the number of each performed by the selected resident in each of the three roles, as well as the total number for each procedure.
- **Resident Experience Report by Year**  
Programs are unlikely to find this report useful, since it only provides the total number of procedures that is included in the resident experience report by role.
- **Resident Full Detail Report**  
All information for each case entered into the Case Log System is displayed in this report, making this report most useful for getting an in-depth view of a resident's experience during a defined period. For example, this report could be generated for each resident for the preceding 3 month period and used as part of the quarterly evaluation meeting with the program director or designated faculty mentor. The use of filters can be used to provide additional insight into the resident's activities (e.g., filtering for specific settings).
- **Tracked Procedures for Specialty by Category**  
This report generates the CPT codes mapped to each defined case category as well as the CPT codes that are available but not tracked.

The use of filters allows the program to get specific information to use for targeting needed program improvements. For example, selecting a specific institution would provide data on that institution's contribution to the surgical/clinical activity in the program. If the institution was added with the goal of providing specific abdominal procedures, the program could determine if this goal was being met. Programs are encouraged to incorporate these tools as part of their program improvement activities.

## Fields

Resident:	Resident name is automatically entered based on the user login.
Attending:	Attending Physician name. This must be one of the program attending identified in the ACGME Case Log System. Ask your program director for a list.
Institution:	Select the institution where the case/encounter was performed.
Resident Year:	Select the resident's year in the program. The choices available are "all" and "1." For colon and rectal surgery programs, these are the same.
Resident Role:	Select the role from the drop-down list: Surgeon, Assistant, or Teaching Surgeon.
Date:	Enter date of case/encounter (Format: mm/dd/yyyy).
Case ID:	A unique identifier for the individual patient (typically, their medical record number).
Code:	All available CPT and ICD9 codes can be obtained by generating the report "Tracked Procedures for Specialty by Category." Consult the Resident User Guide from the Reference Materials within the Case Log System for information on how to use the search options. 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 category called "Miscellaneous."
Description:	This is the CPT/ICD9 code description. It appears in two of the available reports in the Case Log System: "Tracked Procedures for Specialty by Category;" and "Resident Full Detail Report." This field is populated by the database based on the CPT/ICD9 code the resident chooses.
Area:	The area is the broadest category of procedure/diagnosis the Review Committee is tracking.
Type:	This is the procedure/diagnosis category that the Review Committee is tracking.
Comment:	This is a free text field for residents to enter notes about the patient and/or procedure. This is not a mandatory field.

## Glossary

ACGME	The Accreditation Council for Graduate Medical Education, the body that oversees and accredits all medical residency education the in the United States
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