



Case Log Guidelines

Review Committee for Neurological Surgery

Resident Role:

Resident surgical procedures must be entered into the ACGME Case Log System. Residents must indicate their major role in each case: Assistant Resident Surgeon, Senior Resident Surgeon, or Lead Resident Surgeon. The definitions for these roles are:

- **Assistant resident surgeon:** includes positioning, sterile preparation, placement of monitoring devices, microscope preparation, participation in the initial (opening) or final (closing) portions of the case, and/or assisting the resident or staff surgeon(s)
- **Senior resident surgeon:** may include aspects of the above, and must include participation in the surgical procedure between opening and closing
- **Lead resident surgeon:** may include aspects of the above, and must include participation in the critical portion of the case

To claim a case, a resident must scrub in for the procedure (i.e., scrub hands, use sterile gloves, with or without gown). There can be several residents per case, but each resident may claim only one role per case (Assistant, Senior, or Lead). There can be only one Lead Resident Surgeon per case, but the Assistant and Senior Resident roles are not limited in number per case. Only those cases completed in the role of Senior Resident Surgeon or Lead Resident Surgeon will count towards the required minimum Case Log numbers. However, the Review Committee expects that the Case Log data will demonstrate increasing participation and progressive responsibility.

Credit:

Each resident may enter one or more CPT codes per case, but may claim credit for only one CPT code per case. If more than one resident participated in the same case, each resident may claim the same CPT code for credit for that case as appropriate, as long as the claimed roles are not the same, except for the Assistant Resident Surgeon role. For example, one Assistant Resident Surgeon may claim a CPT code for credit when participating in the initial (opening) portion of the case, while another Assistant Resident Surgeon may claim the same CPT code for credit when participating in the final (closing) portion of the same case. See critical care guidelines below for further information.

Patient Type:

- The Review Committee defines a pediatric patient as one who is less than 18 years old at the time of the procedure.
- An adult patient is defined as one who is 18 years or older at the time of the procedure.
- A pediatric patient who is 18 years or older at the time of a follow-up procedure must be logged as an adult patient.

Specific Coding Guidelines:

- **Airway Management:** The requirement for 10 procedures in this defined case category can be met by multiple procedures, including intubation, tracheostomy, thoracentesis, tube thoracostomy, and bronchoscopy. Bundling of CPT codes occasionally prevents a granular description of a procedure that is of interest to the Review Committee and central to neurological surgery education. Simple intubation, now bundled with anesthesia or critical care provision, is an example. Residents should search under DC26 (airway management) for the following code:

31575 (laryngoscopy, flexible fiberoptic; diagnostic)

Though direct laryngoscopy is only a component of intubation and may not be performed fiber-optically, coding intubation in this manner will ensure appropriate credit.

- **Critical Care:** Residents are required to log 90 care critical procedures. Residents can pair one or more of these minor procedure codes with the primary code for a major procedure for a particular patient care episode. For example, if a resident intubates a patient, places a central line, and participates in a lumbar fusion, he or she may log a primary code for airway management as one case, a primary code for central line placement as a separate case, and a primary code for the lumbar fusion as a third case. Other elements of the spine surgery must still be included as secondary codes within the lumbar fusion case.

Review Committee Expectations:

Residents graduating in 2014-2015 are expected to demonstrate compliance with all minimum numbers, except for the critical care (DC20-28) and endovascular (DC3b) procedures. Beginning with the 2015-2016 academic year, all program graduates are expected to demonstrate compliance with all minimum numbers without exception.

Monitoring 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 a program's residents. Filtering by specific CPT code, resident year, attending, participating site, etc. 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 be especially helpful in monitoring the procedures that do not count towards the minimums. Choosing non-tracked codes on the area drop-down menu will show the CPT codes that have been entered but that 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 if it really was a minor procedure that doesn't fit into the Review Committee minimum requirements.

- **Minimums Report**

To track resident progress toward achieving minimum numbers, a separate report should be generated for each resident using the default settings ("credit" should be "primary"). Note that the cases reported in the Assistant role do not count for credit; subtract this number

from the total to calculate the accumulated cases that count toward the required minimum numbers.

- **Resident Activity Report**

This is a summary report that provides total number of cases, total number of CPT codes, last procedure date, and last update date for each resident or for a 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**

This 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 is very similar to an expanded version of the Minimums Report. It is formatted the same way, but omits the required minimum number for each defined case category, while including procedures that do not have a minimum number required.

- **Resident Experience Report by Year**

This report summarizes the number of cases for each defined case category for each of the seven post-graduate (PG) years. It provides a quick way to see which procedures are most common for each PG year. Like the Code Summary Report, the Resident Experience Report by Year will provide useful information for monitoring surgical activity in the program, and could be used to determine if changes to curriculum rotation schedules, etc., are needed.

- **Resident Full Detail Report**

All information for each case entered into the Case Log System is displayed in this report, making it most useful for getting an in-depth view of a resident's surgical experience during a defined period. For example, this report could be generated for each resident for the preceding six-month period and used as part of the semi-annual evaluation meeting with the program director or designated faculty mentor. The use of filters is therefore recommended.

- **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 a 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 activity in the program. If the institution was added with the goal of providing functional procedures, the program could determine if this goal was being met. Similarly, the number of pediatric patients contributed by each institution could be tracked using the patient type filter. Programs are encouraged to incorporate these tools as part of their program improvement activities.