



Tutorials and Guidelines on Use of the ACGME Case Log System for Dermatology Residents November 2014

I. General orientation of user to dermatology procedural case entry screen

A feature unique to the Dermatology Case Log System is that:

procedures, designated by a CPT code, are entered in relation to the lesion being treated.

Therefore the labeling of each lesion you treat is critically important for your procedure log. The following Case ID naming convention must be followed in order to generate meaningful Case Log reports:

Enter the patient's initials, followed by a Case ID number consisting of at least two digits.

Patient example: If you treat the patient Joseph Patrick Smith on July 1 for a 1) basal cell carcinoma on his nose, 2) a cyst on his back, and 3) a wart on his toe, you would enter the procedural data for each lesion in its own distinct case data entry screen as described below. The first **Case ID** would be JPS01, the second JPS02, and the third JPS03.

First case data entry screen: If you were involved in the performance of three stages of Mohs surgery and a layered closure on the nose, then the CPT codes used for billing these two procedures (Mohs and closure) would be logged in association with Case ID JPS01. Once saved, a second data entry screen would be opened to enter data on the second lesion.

Second case data entry screen: The CPT codes for excision and complex repair for the cyst would be logged in association with the back lesion or JPS02. This would be saved as an individual entry, even though it occurred on the same patient on the same day. Next, open a third data entry screen for the third lesion.

Third case data entry screen: The CPT codes for laser destruction of the wart would be logged in association with the toe lesion or JPS03. This would be saved as the third discrete entry for this patient, thereby completing entry of all procedures performed by you on Mr. Smith on July 1.

II. Manual fields clarification

Residents Role Definitions

Resident Surgeon—Scrubbed in and performed majority of the procedure

Observer—Observed or assisted the surgeon who performed the procedure

Primary Provider—Responsible for the diagnosis, treatment, and management decisions of the patient (can be supervised by an attending); or counseled the patient about a procedure, performed the key aspects of the procedure, and managed the outcome or complications of the procedure

CPT Code

Direct enter, or use the search function to select, the CPT code that best represents the procedure performed on the lesion for which data is being entered.

III. How to enter multiple procedures performed on same lesion during same encounter

When the Resident Role is the same for all procedures for a particular Case ID:

The Case Log System is designed to allow the entry of multiple CPT codes in the same case data entry screen for a single Case ID. You will receive credit in the Case Log reports for each of the procedures entered. In the example of Mr. Smith above, if you were the “Resident Surgeon” and treated lesion JPS02, you would enter “11402” for excision of the 1.5cm cyst, as well as “13101” for the complex closure of the resultant defect. When the Resident Operative Experience Report is generated, you would receive one count credit in the Resident Surgeon column for both “Excision – Benign Lesion” and “Repair (Closure).”

When the Resident Role differs for your involvement in the procedures performed for a particular Case ID:

If you perform the excision on Mr. Smith but then observe a colleague perform the complex closure, you would fill in two case data entry screens for lesion JPS02. In the first screen you would designate the Resident Role as “Resident Surgeon,” and enter “11402” in the CPT code box. After saving the first entry you would complete a second case entry screen in which you would select “Observer” for the Resident Role, and enter “13101” in the CPT code box. In both screens you would enter JPS02 in the Case ID box.

IV. How to enter Mohs cases

For a particular Case ID treated with Mohs surgery, it is important to include all of the appropriate Mohs codes and repair codes that are used:

Mohs Codes

Use the appropriate site-specific CPT code for each stage of Mohs surgery by entering codes in the CPT box one at a time. For example, if lesion JPS01 on Mr. Smith’s nose is treated with three stages of Mohs surgery, you would enter “17311,” “17312,” and “17312.” If JPS01 had been on the trunk, then you would have entered “17313,” “17314,” and “17314.”

Mohs Defect Disposition

If a repair procedure is performed on a Mohs defect, enter the appropriate CPT code for the repair in the data entry screen in which you enter the Mohs codes. In the example case of Mr. Smith, after entering the Mohs codes, you would enter “13151” if a 1.2cm layered closure was performed on lesion JPS01 following completion of the Mohs surgery.

If for lesion JPS01 you observed the Mohs procedure performed by your attending physician, and then the attending supervised you as you performed the repair, you would fill in two case data entry screens as detailed above.