Case Log Coding Guidelines
Review Committee for Otolaryngology - Head and Neck Surgery

These **Case Log Coding Guidelines** are provided to establish uniformity for logging cases in the ACGME's Resident Case Log System for Otolaryngology - Head and Neck Surgery. A set of **Frequently Asked Questions** is also included.

The Review Committee defines the role of the resident surgeon in the case as follows –

- **Resident Assistant Surgeon**: An assistant surgeon performs less than 50 percent of the procedure, or greater than or equal to 50 percent, but not the key portion(s) of the procedure. To claim a procedure, a resident must "scrub in." Being present in the room as an observer does not count as having served as an assistant surgeon.
- **Resident Surgeon**: A resident surgeon performs greater than or equal to 50 percent of the procedure, including the key portion(s) of the procedure, with the attending surgeon and/or resident supervisor (if applicable).
- **Resident Supervisor**: A resident supervisor instructs and assists a more junior resident through a procedure during which the junior resident performs greater than or equal to 50 percent of the procedure including the key portion(s). The attending surgeon functions as an assistant or observer in such circumstances.

There are some KEY points to remember in coding cases.

1. **Coding cases for the ACGME is NOT the same approach as coding for billing**. For the purposes of Case Log coding, operations are to be unbundled into their separate components to capture the surgical experience. Unbundling is not usually allowed in the case of billing.
2. **Be conscientious and thorough about coding**. Case Logs should reflect the hard work a resident has done in the program. Residents should take credit for what they have performed and code cases appropriately using the tracked codes database. Pay special attention to laser, robotic, sialendoscopy, and ultrasound experience (listed under the **"special equipment"** drop-down menu), as these categories of procedures often require additional documentation when applying for privileges.
3. **Unbundle cases into their major components using tracked codes**. For example, a case involving a tympanoplasty with mastoidectomy and ossicular chain reconstruction should be coded as three separate procedures. A cochlear implant should be coded as a mastoidectomy and a CI.
4. **Other than the three Ts (turbinates, tonsils, and tubes), which are coded per patient, all other cases are to be coded per side**. For example, performing a bilateral neck dissection results in credit for two neck dissections. For a total thyroidectomy, if the resident is the resident surgeon for the entire case, it should be coded as one total thyroid. If the resident is the assistant surgeon for one side and the resident surgeon for the other side, the case should be coded as two thyroid lobectomies, once under resident surgeon and once under assistant surgeon.

5. **Some codes have been assigned to particular categories to capture operative experiences, which may differ from the typical use of the CPT® code**. The most notable example is 60252 which is being used for case logging purposes to capture central compartment neck dissection (and if done bilaterally this should be coded twice). Bundled CPT codes that include both excision of a lesion and a specific reconstruction have had their descriptions edited so that the CPT code reflects only the excision (with primary closure), and a separate CPT code must be used to capture the appropriate reconstructive procedure (e.g., rotational flap). Bundled CPT codes that contain the primary extirpative procedure and a neck dissection do not appear in the tracked codes database as these cases should be logged once with the appropriate code for the resection and again with a separate neck dissection code.
6. **All CPT codes appear only once in the database of tracked codes with the exception of ossicular chain reconstruction as there are no separate CPT codes for OCR** (all CPT codes for OCR also include tympanoplasty).
7. **All attempts should be made to use the closest corresponding tracked code.** Not all CPT codes appear in the tracked codes database because the Review Committee wanted to simplify the codes into smaller, meaningful categories or to require unbundling as explained in key point #5. This required the elimination of codes that were not used often and/or for which the work was captured by a code already in the tracked codes database. For example, there is only one code for a tongue biopsy and or image-guided needle biopsies in the tracked codes database even though there are multiple billing CPT codes which vary based on the anatomic location of the biopsy or the imaging modality used, respectively. Residents should NOT use untracked codes when logging otolaryngology cases, but rather the best code in the tracked codes database.
8. **Key Indicator Procedures**

Category	Procedure	Min #
KEY INDICATOR: Head and Neck	Parotidectomy (all types)	**15**
	Neck Dissection (all types)	**27**
	Oral Cavity	**10**
	Thyroid/Parathyroidectomy	**22**
KEY INDICATOR: Otology/Audiology	Tympanoplasty (all types)	**17**
	Mastoidectomy (all types)	**15**
	Ossicular Chain Surgery (OCS)	**10**
KEY INDICATOR: FPRS	Rhinoplasty (all types)	**8**
	Craniomaxillofacial Trauma (CMF)	**12**
	Flaps and Grafts	**20**
KEY INDICATOR: General/Pediatrics	Airway – Pediatric and Adult	**20**
	Congenital Masses (CM)	**7**
	Sinus (Ethmoidectomy)	**40**
	Bronchoscopy	**22**

9. **There four areas of patient management that help capture the non-surgical aspects of otolaryngology - head and neck surgery: Infant with stridor; Infant with hearing loss; Complications of sinusitis; and Complications of otitis media.** It is mandatory

for a resident to log participation in the care of patients with these diseases to demonstrate the resident's exposure to them. These experiences only need to be coded once per patient even if the resident sees the same patient multiple times throughout the course of the disease process.

FREQUENTLY ASKED QUESTIONS

Q. How does one add cases to the ACGME Case Log System?

A. Enter in all known information into each of the available drop-down fields in the Case Log System. Each starred (*) field is required to successfully add the case.

The “equipment” field has been recently added to allow for further specification of the use of special equipment during cases. Clicking this field allows for the addition of various lasers (e.g., CO2, argon), or signifying that this was a robotic surgery. The equipment field has a default value of “NA” that the system will accept without any changes. Change this field if various lasers or a robot was used during the case to give a greater degree of depth to the Case Log.

Q. How does one search for a particular code for a case?

A. Towards the bottom of the Case Log screen are three tabs: “Favorites;” “Area/Type/Code;” and “Key Indicator.” Clicking on the “Area/Type/Code” tab will bring up another set of three drop-down menus which can be used to view all of the surgical sub-categories and their respective cases. Clicking the “Area” tab will open a list of sub-categories such as “General/Peds-Congenital Anomalies” and “Head and Neck-Endocrine.” Selecting one of these options and clicking search will yield a list containing all of the cases within that surgical domain. Cases can then be added to the case log system by selecting “add.”

Alternately, use the available “code or keyword” search bar to type in the exact CPT code of the case or a select keyword used to describe the case performed. For instance, type in the keyword, “thyroidectomy” or simply “thy” into this field to open a list of various cases containing the word “thyroidectomy” or the letters “thy.” Then look through this list to find the appropriate case to add to the log. However, if the exact CPT code for the case performed is known, this may be typed into the field instead. For example, typing in “60240” will directly find the case corresponding to “Thyroidectomy, total or complete.”

Q. How does one search for and log key indicator cases?

A. Towards the bottom of the Case Log screen are three tabs: “Favorites;” “Area/Type/Code;” and “Key Indicator.” Clicking on the “Key Indicator” tab will bring up another drop-down menu containing all of the various sub-categories of key indicators (e.g., congenital neck masses, flaps and grafts, rhinoplasty). Selecting one of these larger sub-categories and then clicking “search” will bring up a list of all the possible cases which can be used to satisfy this key indicator category.

For instance, selecting the category “Congenital Neck Masses” and then clicking search will yield a list containing cases such as “excision dermoid cyst, nose; simple, skin, subcutaneous,” and “excision of thyroglossal duct cyst or sinus,” among others. Cases such as these can be coded and logged to satisfy the larger requirement of “Congenital Neck Masses.” Cases can then be added to the Case Log System by selecting “add.”

Q. How does one create a "favorites" list?

A. Creating a "favorites" list is helpful to access and add cases performed frequently or to avoid having to search again for previously encountered cases. When searching for cases as described above, a yellow star can be seen next to each individual case under the "Fav" column. Clicking on the yellow star will open an additional window allowing the user to both create and add the selected case to a particular favorites list. This favorites list can be accessed by clicking on the "Favorites" tab towards the bottom of the Case Log screen. After clicking this tab, a drop-down menu is viewable with any number of previously created lists.

Q. Does a pediatric laryngotracheal examination with a laryngoscope and a telescope count as a bronchoscopy Key Indicator Case? *[Program Requirement IV.B.1.b).(2).(d).(iii)]*

A. No, such an examination does not count as a bronchoscopy key indicator case because there is no utilization of a bronchoscope and the entire lower airway is typically not examined.

Q. In a total thyroidectomy, if the parathyroid is explored or examined but not removed, can this procedure be counted as a parathyroidectomy in the Case Log System? *[Program Requirement: IV.B.1.b).(2).(c).(vi)]*

A. No. Parathyroid glands are commonly seen during a thyroidectomy, but the parathyroidectomy code assumes a proper parathyroid workup has been accomplished pre-operatively, and that the surgical approach is primarily for parathyroid removal. Unless this evaluation is performed, the parathyroidectomy code should not be used.

Q. Can surgical procedures done on non-otolaryngology - head and neck surgery rotations in other ACGME-accredited programs be entered in the resident's otolaryngology Case Logs? *[Program Requirement: IV.C.10.b)]*

A. A resident can choose to keep a record of all procedures, but for the purposes of the Review Committee, only the otolaryngology - head and neck surgery procedures should be entered into the Case Log System.

Q. Can operative procedures done during an international rotation be counted toward Case Log minimums? *[Program Requirement: IV.C.11.d)]*

A. No, procedures performed during an international rotation may not be counted in the Case Log System.

Q. How should residents code for procedures that include several major components, such as laryngopharyngectomy with bilateral neck dissection, in the Case Log System? *[Program Requirement: IV.C.10.b)]*

A. Residents should use the CPT code for laryngopharyngectomy to reflect the extirpative

procedure and code each neck dissection side separately. An additional code would be needed to capture the reconstruction. Yet another code would be used if an additional reconstructive procedure were used on the donor site (as in the case of closing a forearm donor site with a skin graft). Therefore, a patient undergoing such a complex operation would require entering at least five CPT codes (one for the primary resection, two for the bilateral neck dissection, one for the free flap, and one for the graft to close the donor site).

Q. Why must all residents in a program have essentially equivalent distributions of case categories and procedures? *[Program Requirement: IV.C.10.b).(1)]*

A. The Review Committee expects that residents' educational experience should be fairly equivalent within a program so that all graduates have sufficient volume and variety of educational experiences to prepare them for independent practice as a general otolaryngologist. The Committee sees a significant parity issue if one resident has had an insufficient experience in a particular clinical area, while the other residents in the program have had an excess experience. Generally, disparities in case numbers between graduating chief residents are not seen as significant if there are no areas of clinical deficiency (i.e., all key indicator procedure minimums are met).

Q. What are the Review Committee's expectations for entering operative procedures into the Case Log System? [*Program Requirement: IV.C.10.f).(2)]*

A. Residents must use the definitions provided for assistant surgeon, resident surgeon, and resident supervisor to accurately describe their participation in the case. Residents should discuss with the attending surgeon at the end of the case how to correctly identify themselves if there is any doubt as to the level of participation.

- **Resident Assistant Surgeon**: An assistant surgeon performs less than 50 percent of the procedure, or greater than or equal to 50 percent, but not the key portion(s) of the procedure. **To claim a procedure, a resident must "scrub in." Being present in the room as an observer does not count as having served as an assistant surgeon.**
- **Resident Surgeon**: A resident surgeon performs greater than or equal to 50 percent of the procedure, including the key portion(s) of the procedure, with the attending surgeon and/or resident supervisor (if applicable).
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Some cases have multiple procedures, each allowing for different levels of resident participation. Each resident may claim only one role per procedure (i.e., one cannot be both the teaching surgeon and the primary surgeon for a specific portion of the case). Two residents cannot claim the same role for any specific procedure other than assistant surgeon.

Examples:

1) Two residents scrub in with an attending on a parotidectomy with neck dissection. Resident A performs more than 50 percent of the key portions of the parotidectomy while Resident B assists. The residents switch roles for the neck dissection procedure, with Resident B performing less than 50 percent of the procedure and the key portions. In this case, Resident A will code **Resident Surgeon** for the parotidectomy and **Assistant Surgeon** for the neck dissection; Resident B will code **Assistant Surgeon** for the parotidectomy and **Resident Surgeon** for the neck dissection. If the attending surgeon allows Resident A to serve a supervisory role for Resident B on the neck dissection, then Resident A should code the Neck Dissection as **Resident Supervisor**.

2) Two residents scrub in on an endoscopic sinus surgical case involving bilateral total ethmoidectomies and sphenoidotomies. Resident A performs the procedures on the right side while Resident B observes. Resident B performs the procedures on the left side with Resident A supervising. Resident A would code a total ethmoidectomy and sphenoidotomy as a **Resident Surgeon** for the right sided procedures, and a total ethmoidectomy and sphenoidotomy as a **Resident Supervisor** for the left sided procedures. Resident B would code a total ethmoidectomy and sphenoidotomy as a **Resident Assistant** for the right sided procedures, and a total ethmoidectomy and sphenoidotomy as a **Resident Surgeon** for the left sided procedures.

Procedures performed by residents in the roles of **Resident Surgeon** and **Resident Supervisor** count towards the minimum Case Log requirements. The Review Committee, however, emphasizes the importance of the **Assistant Surgeon** role as the individual resident's Case Log data must demonstrate progressive participation and responsibility.

Program directors must monitor the timely entry and accuracy of their residents' procedures in the Case Log System. Cumulative key indicator reports generated from the Case Log System should be reviewed with each resident at least on a semiannual basis as part of the resident assessment process with respect to the development of each resident's surgical skills.

Q. How should the program document progressive resident performance improvement and improvement toward unsupervised practice? *[Program Requirement: V.A.1.c).(2)]*

A. Residents should be formatively evaluated based upon the progressive educational expectations delineated in the program's goals and objectives. In terms of the program's progressive operative education, all residents must have the opportunity to start as an "assistant" before becoming the "surgeon" for procedures. Some residents may take longer than others to progress to the "surgeon" level. The assistant/surgeon case ratio is reviewed by the Review Committee.

Q. How should residents' Case Logs be monitored? *[Program Requirement: V.A.1.d).(1).(a)]*

A. 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 at a minimum as part of the 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.

- **Experience by Role Report**
  This report lists the number of cases at each participation level.
- **Experience by Year Report**
  This report summarizes the total number of logged for each of the five PG years. It provides a quick way to see which procedures are most common for each PG year. Like the Code Summary Report, this report will provide useful information for monitoring surgical activity in the program and could be used to determine if changes to curriculum rotation schedules are needed.
- **Log 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 all residents 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 a 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.
- **Case 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.
- **Case 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 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.
- **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 member 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 drop-down 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 a resident miscoded something that should be adjusted, or if it was a minor procedure that doesn't fit into the Review Committee minimums.
- **Tracked Codes Report**
  This report generates the CPT codes mapped to each defined case category, as well as the CPT codes that are available but not tracked. **Use this report as a guide when completing the institutional case report form required for complement increase requests**.

- **Otolaryngology - Head and Neck Surgery Key Indicator and Minimum Report**
  To track resident progress toward achieving minimum numbers, a separate report should be generated for each resident using the default settings. 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 number.

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 had been added with the goal of providing functional procedures, the program could determine if this goal were 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.

Send additional questions to Review Committee Staff, contact information for whom can be found in the specialty section of the ACGME website.