Tutorials and Guidelines on the Use of the ACGME On-line Case Log system for Procedural Dermatology Fellows
June 2011

I. Accreditation Data System (ADS) Case Log Tutorials

A tutorial specifically for Procedural Dermatology fellows is in preparation and until it is available you are encouraged to review the information at the following sites. Please remember that some of the details discussed in these tutorials are not relevant to Procedural Dermatology:

http://www.acgme.org/residentdatacollection/documentation/tutorials/CAMTASIAWMV/quickstartWMV/quickstart17_media/quickstart17.wmv

http://www.acgme.org/residentdatacollection/documentation/tutorials/CAMTASIAWMV/generalsurgerycaseentryWMV/generalsurgerycaseentrywmv/generalsurgerycaseentrywmv_media/generalsurgerycaseentrywmv.wmv

II. General orientation of user to the Procedural Dermatology data entry screen

A feature unique to the Procedural Dermatology case log system is that:

Procedures 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 lesion ID naming convention must be followed in order to generate meaningful case log reports:

Enter the patient's initials followed by a lesions number consisting of at least 2 digits.

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

First data entry screen: If you performed 3 stages of Mohs surgery and a rhombic flap on the nose, then these 2 procedures (Mohs and flap) and all relevant data (see below) would be logged in association with lesion JPS01. Once saved a second data entry screen would be opened to enter data on the second lesion.

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

Third data entry screen: The laser destruction of the wart would be logged in for JPS03. This would be saved as the third individual entry for this patient thereby completing entry of all procedures performed on Mr. Smith on July 1st.

III. Manual fields clarification

<u>Fellow Role Definitions</u>
Fellow Surgeon: Scrubbed in and performed majority of the procedure.
Assistant: Scrubbed in and assisted other fellow or attending who performed majority of the procedure.

<u>CPT Code</u>
Direct enter or use the search function to use the CPT code that best represents the procedure performed on the lesion for which data is being entered.

IV. Use of Mohs codes

When Mohs codes are entered for any Lesion ID then the following must be entered in the data entry screen:

<u>Mohs codes</u>
Use the appropriate site-specific CPT codes for each stage of Mohs surgery by entering them in the CPT box one at a time. For example, if lesion JPS01 on the nose was treated with 3 stages of Mohs surgery then enter 17311, 17312 and 17312. If JPS01 had been on the trunk then 17313, 17314 and 17314 would have been entered for JPS01.

<u>Mohs Defect Disposition</u>
All Lesion IDs for which a Mohs code is entered must be accompanied by a code entry for only one of the following:
1) CPT code for the repair procedure (If a flap code is used the user will be required to designate the type of flap as well).
2) The case log code for second intention (code: 17999)
3) The case log code for referral to another repair physician (code: 17999)

<u>Post Mohs Defect Size</u>
Select from the drop down list the most appropriate range of dimension that encompasses the greatest diameter of the Mohs defect at the completion of the final stage of Mohs surgery. This is also referred to as the "final defect" size.

<u>Complex Mohs Case</u>
Check this box if the lesion is one or more of the following:
1) Histologically aggressive tumor
2) Large tumor (entire cosmetic unit, scalp tumors > 5 cm)
3) Tumor located in peri- auricular, orbital, anal sites; intranasal and nail bed
4) Tumor other than BCC or SCC
5) Tumor involving bone
6) Tumor requiring > than four stages
7) Multiply recurrent tumor
8) Tumor requiring a multidisciplinary team surgical approach
9) Patient requiring special intraoperative management

<u>Recurrent Lesion designation</u>
Check this box if the lesion has recurred following previous attempts to treat.