

The American Board of Plastic Surgery, Inc.®



**2016 HAND SUBSPECIALTY CERTIFICATION
(HSC)**

CLINICAL CASE LOG MANUAL

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Email: hand@abplasticsurgery.org

ABPS Website: <https://www.abplasticsurgery.org>

**Clinical Case Log:
<https://secure.dataharborsolutions.com/clinicalcaselog>**

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HAND SURGERY EXAMINATION (HSE) IMPORTANT DATES AND DEADLINES

HAND EXAM - COMPUTER BASED TEST (CBT)	SEPT. 8, 2016
HAND RECERTIFICATION EXAM - CBT	SEPT. 8-22, 2016
HSE Online Application available	December 1, 2015
Last Date to Request HSE Application Material	January 4, 2016
Deadline - HSE Applications Finalized	February 2, 2016
Applications Finalized with Late Fee	February 3-9, 2016
Application Approval Letters and online Reply Forms available	March 1, 2016
Deadline - HSE Online Reply Forms Finalized	March 31, 2016
Reply Forms Finalized with Late Fee	April 1-7, 2016
HSE Scheduling Permits available	Early July 2016
Hand Exam Withdrawal Date with Partial Refund	August 8, 2016
Hand Exam for Initial Subspecialty Certification	September 8, 2016
Hand Exam for Recertification	September 8-22, 2016
Hand Exam Results mailed and available on the Board's website after secure login.	November 2016
Hand Subspecialty Certificates mailed from the Board Office	December 2016
Deadline - 2016 MOC-PS® Primary Certification Exam Reply Form*	January 15, 2016
Deadline - 2017 MOC-PS® Exam Application and Clinical Log	September 1, 2016

Board Office Policies and Reminders

- The Board Office is unable to verify receipt or completeness of materials by telephone.
- Diplomates with incomplete materials will be notified via email.
- Incorrect or incomplete submissions (document uploads) may result in a Missing Items Penalty Fee.
- The Board Office is unable to accept faxed or emailed documents in lieu of required uploads to the Application or Reply Form. Contact the Board Office for assistance.
- Payment of Examination Fees is accepted only by credit card – VISA, MasterCard or American Express.
- Reissue of Board letters or documents requires a photocopying fee.
- Notification of change in address, telephone number, email, etc. must be updated on the Board's website under "My Profile" after secure log in.
- Note all Board deadline dates carefully to avoid penalties or exclusion from the examination.
- Stay current on all Board requirements via the Board's website.
- If you need assistance, please contact the Board Office at hand@abplasticsurgery.org.

THIS BOOKLET OF INFORMATION SUPERSEDES ALL PREVIOUSLY PUBLISHED BOOKLETS OF INFORMATION OF THE BOARD CONCERNING REQUIREMENTS, POLICIES AND PROCEDURES AND MAY BE MODIFIED AT ANY TIME.

Hand Surgery Examination for MOC Examination Credit

The Hand Surgery Recertification Examination may be used in lieu of the **AMCC-PS®** Modular Examination to renew primary certification and to continue in the **AMCC-PS®** Program.

- ❖ The Hand Surgery Recertification Examination must be completed within the current 10 year MOC Cycle.
- ❖ Applications are required for both the primary (**AMCC-PS®**) and HSE processes.
- ❖ Expiration of the diplomate's primary plastic surgery certificate automatically causes expiration of the Hand Subspecialty Certificate.
- ❖ If primary certification is lost, admissibility to the HSE process can be reinstated with the renewal of the primary certification by completing the Maintenance of Certification Examination and all requirements.

***Diplomates with primary certificates expiring on 12/31/2016 (and who have an approved **AMCC-PS®** Application) may prefer to take both the April **AMCC-PS®** Examination and the September 2016 Hand Surgery Examination. Please notify the Board Office by December 15th if the **AMCC-PS®** Reply Form is needed.**

TABLE OF CONTENTS

Case Collection Requirements and Information (n/a for Recertification)	5
Instructions for Data Compilation	7
Clinical Case Log Manual	11
CPT Codes	15
Outcomes and Adverse Events	17
Submitting Material to the Board Office	20
Sample Screens	21
FAQ's	33
Fees	Inside Back Cover

**THE HSE CASE LIST AND HSE APPLICATION MUST
BOTH BE FINALIZED BY
FEBRUARY 2, 2016.**





**For questions or concerns, please contact the
Board Office staff at hand@abplasticsurgery.org.**


Clinical Case Log (CCL) Collection Requirements and Information

Case Collection is required for initial Hand Subspecialty Certification only. The CCL is not required for Recertification.

Log In Instructions

Diplomates can log in to begin the Clinical Case Log by following the below instructions:

-  You are pre-registered on the Board's website, www.abplasticsurgery.org, and on the Clinical Case Log website, <https://secure.dataharborsolutions.com/clinicalcaselog>. The Board recommends setting links to both websites on your desktop.
-  **You can also access the Clinical Case Log link via your Hand tab on the Board's website.**
-  Your username and password have been preset by the Board. Your username is your six digit Board ID number and your password is your last name with the first letter capitalized (e.g. Smith). 2015 Oral Exam Candidates will use the same username and password that was used for submission of the 2015 Oral Exam Reply Form.
-  The default password and username for the Board's website and the Clinical Case Log website are identical. If you change either of the passwords or usernames you should change it on both the Board's website and the Clinical Case Log website.

 On the profile screen of the CCL you are required to indicate the start date of your 15-month Hand Surgery case list.

The Clinical Case Log compilation program is a web-based application hosted by Web Data Solutions, LLC. The program provides a standardized case list format that facilitates the Board's review. You must have internet access to complete the case list compilation. It is strongly recommended that you dedicate approximately 30 minutes to thoroughly review all requirements for case list compilation before beginning the case collection process.

Required fields are noted with an asterisk and are outlined with a red box (incomplete) until data is entered.

All cases entered during the 15-month time frame you specified on the profile screen will appear on the **“Hand Mode”** of the Clinical Case Log.

The online submission of the Case List must be “finalized” by the deadline date.

A hard copy of the case list is not required.

The Board advises that diplomates keep an electronic or printed copy of their case list for their records.

Data Compilation Requirements

1. You must submit a 15 consecutive month case list for hand surgery cases performed within the two years preceding submission of the Application Material. The case list must include at least 125 hand cases during the 15-month period.
2. Do not list assistant cases, namely cases billed by the diplomate as an assistant surgeon. Cases performed by a resident and attended by the diplomate, or cases billed as co-surgeon should be included on the case list, and noted as such in the procedure section. Co-surgeon cases must include evaluation, surgical plan and follow-up care of the patient.
3. Do not list voluntary surgical activity in developing countries. Cases performed during such service are not to be included in case compilation because of the lack of continuum of care.
4. The list must include multiple operative procedures performed on the same patient. This inclusion allows automatic cross-referencing by the computer program. However, hospital (or other) identifying numbers and patient initials must be consistent for the patient with multiple procedures (i.e. if a patient is listed at more than one institution, the same identifying number must be used to identify the patient).
5. All operative procedures on the upper extremity distal to the elbow joint must be included whether inpatient, outpatient, or office-based surgery during the 15-month reporting period. All patients hospitalized by the diplomate as the admitting physician must also be included, even if the patient is managed non-operatively. Office-based surgery that does not require a dictated note does not need to be included. However, the Board suggests that the diplomate err

in the direction of inclusion of cases rather than exclusion. Do not include inpatient consultations on patients admitted by physicians on other services that did not culminate in a surgical procedure. All emergency room patients who required an operative note must be included.

6. The automatic CPT code descriptors, which are visible when a CPT code is entered, are the copyright of the American Medical Association (AMA). A CPT code frequency field is included so that a CPT code may be entered once with the number of times the procedure was performed (e.g. X2, X3, etc. for multiple skin grafting procedures).
7. The case list must include at least 125 cases fulfilling at least five of the following nine categories:

CATEGORY/CLASSIFICATION # OF CASES

Bone and Joint (distal to the elbow joint) . .	20
Nerve	20
Tendon and Muscle	20
Skin and Wound Problems	14
Contracture and Joint Stiffness	10
Tumor.	10
Congenital.	3
Microsurgery Vascular.	3
Nonoperative.	6
(No more than 6 nonoperative cases can be listed)	

Applicants who do not fulfill the practice requirements may petition the Credentials Committee of the Board for individual consideration. This consideration will take into account other contributions and dedication to the discipline of hand surgery such as teaching, publication, administration, and research.

8. Case classification is a two-part item in order to reduce the category overlap. The **Category** relates to the nature or origin of the defect. The **Anatomy** relates to the anatomical location of the procedure (**Choose Hand as the Anatomy for Hand Surgery case collection**). In the Clinical Case Log screen, these fields become available when the *Add CPT Code* option is clicked. One selection from each column is required. The Board Office staff cannot advise the Diplomate on how to classify a case. Diplomates should use their professional discretion to make the most reasonable assignment for each case.
9. Complex operative management represents a more substantial surgical operative experience than a less complex single task surgery. A complex injury is defined as those cases which involve several of the nine categories in addition to the skin/wound category. Therefore, in an injury involving the volar wrist, multiple tendons and the median nerve would ‘count’ as two categories, tendon and nerve – but not additionally for the skin closure. Further, no single operative case would be allowed to count for more than three categories towards the requirement of 125 cases.

For example, the management of a complex mutilating injury involving repair of muscle, tendon, nerve, vascular injury, and skin would count for tendon and muscle, nerve, and microsurgery vascular, but not for the skin. This example clearly indicates a more complex operative experience than a simple, single task surgery. Those cases in which the involvement of two categories is part of a

single focus surgery, such as the use of a tendon in ligament reconstruction and tendon interposition of the basal joint, would continue to count as only one case.

10. Providing “outcome” information is essential. A complications menu appears when “Adverse Events” is selected. Not all cases "heal without complications." Examples include "necrosis of tip of flap" or "normal sensation returned, but index finger stiff after tendon repair." Complications are displayed on the case list only as a Minor, Moderate or Major Adverse Events. Narrative statements can also be included in the Adverse Events text box. The outcome categories are:

- #1 **No Adverse Events:** No complication or complication so trivial that no intervention is required.

- #2 **Outcome Unknown:** This includes patients **lost to follow-up** and is displayed that way on the case list.

- #3 **Adverse Events:** Check all that apply including delayed healing, infection, unplanned consultation with another specialist, adverse event such as DVT, MI, PE, or Flap loss or unplanned re-operation. A short description of the adverse event is required in the text box provided.

11. Complete the Mortality within 30 days of the procedure box. This is a required field and is displayed on the case list.

CLINICAL CASE LOG WEB MANUAL

Note: These directions will be updated on the website as needed. Also look to the FAQs tab for answers to common candidate problems if they arise.

Technical Assistance is available.

**Please contact Web Data Solutions at
support@datahARBORSolutions.com or 312-944-0642
Monday-Friday: 9:00 a.m. - 5:00 p.m. Central Time**

System Requirements:

In order to use the Clinical Case Log web-based tool you will need a computer with high-speed internet access such as a DSL, Cable or a T1 line. In addition, you will need one of the following web browsers:

- Internet Explorer (version 8.0 or higher)
- Google Chrome (version 26.0 or higher)

Board website: <https://www.abplasticsurgery.org>

Clinical Case Log website:

<https://secure.datahARBORSolutions.com/clinicalcaselog>

Step 1 – Registration

You are pre-registered on the Board's website and the Clinical Case Log website. The Board suggests you create a link to both websites on your desktop. See Log in Instructions on page 5 of this manual.

Login information should be identical now; however, if you change either you should change it in both places – the Board profile and the Clinical Case Log profile.

Step 2 – Setting Up Your Profile

- Log in to the Board’s website to access the Clinical Case Log link through your Hand tab.
- Log in to the Clinical Case Log and read the Terms and Conditions carefully. If you agree to them, click the “Yes” button at the bottom of the page. There is a Business Associate Agreement between yourself and the Board for the confidentiality of the entered data.
- Complete all fields in your profile. The Plastic Surgery Training State must be entered. You may also change your password to something you’ll more easily remember here.
- On the profile screen you must indicate the start date of your 15-month hand surgery case list. All cases entered during the 15-month time frame specified will appear on the hand case list. This is true for cases entered currently and for cases entered in the past. **There is a toggle button that will enable you to switch back and forth between your full case list (Go Mode All) and your hand surgery case list (Hand Mode).**
- Click the “Add Facility” link at the bottom of the page to add facilities at which you have surgical privileges. You will need to complete:
 - ❖ **Facility Name** - Use abbreviations if name of facility is unusually long as this can cause printing problems in the statistics sheet.
 - ❖ **Facility Type** (i.e. Acute Care, Ambulatory Care, etc.)
Note: A designation of Ambulatory Care will dictate an “outpatient” type for all cases listed at those facilities.
 - ❖ **Facility Zip Code**
 - ❖ **Admission Types**
 - ❖ **Surgery Center Accreditation Type**

- Repeat the above process to add more facilities.
- Click on “Save Profile” at the bottom of the page.

**Note: you may return to your profile at any time to add/change data.*

Step 3 – Printing the Sample Forms (not required)

- Click on “Print Forms” in the main menu.
- You will need Adobe Acrobat Reader installed on your computer. If you don’t already have it installed, you can click on the Adobe icon to go to www.adobe.com where you can download Acrobat Reader for free.
- The **Clinical Case Log form** is a sample of the data required for each case.

Step 4 – Collecting Case Data

- Click on Case Log in the main menu.
- Click on “Click here to add a case...”
- All required fields will appear in a red box along with an asterisk. This includes first name and last name of patient. Complete all required fields - **YOU CANNOT FINALIZE YOUR CASE LIST UNLESS ALL REQUIRED FIELDS ARE COMPLETE.**

Patient Information

- *Enter patient name.* Only patient initials (first, middle-if available, last) will be displayed to the Board and on the printed case list. For added confidentiality, use only patient initials.

- *Enter a patient number in the medical record # field.*
Use the same patient number for all procedures for the same patient during the case collection time regardless of the location (e.g. office, outpatient facility, hospital) to allow for cross-referencing. Do not use full social security numbers to protect patient confidentiality. **Please follow your institution's guidelines for patient confidentiality and HIPAA and State requirement compliance.**
- *Enter patient date of birth.* Age in years/months/days will be calculated and displayed on the printed list.
- *Enter patient gender.*

Facility and Procedure Information

- *Enter Hospital Facility Name.* Click on the yellow asterisk/pencil to add/edit the name of a facility.
- *Enter the admission status as inpatient or outpatient.*
An inpatient admission is defined as an overnight stay of one or more nights. An outpatient admission is defined as 23 hours or less.
- *Enter date of procedure.* Multiple procedures on the same patient, on the same date, should be entered as one case. Use the date of admission for non-operative inpatient cases.
- *Enter duration of procedure.* Duration is defined as skin to skin excluding anesthesia time. Approximate duration of the surgical procedure should be entered in hours and minutes.
- *Enter the diagnosis description as free text.* Providing complete diagnosis information is essential. From the operative notes, give an accurate written description of

the diagnosis and the operative procedure(s). **ICD-9 codes are not required.**

- *Enter the procedure description as free text.* Comments about adverse events or death of a patient may also be added here. Do not use CPT codes in place of the written description of the procedure(s). If the case was non-operative, include a discharge summary diagnosis. A text box is also provided for adverse events.

CPT Codes

- *To add a CPT code* – If you know the CPT code(s) for the case, enter the code in the CPT Code box **before** selecting the anatomy and classification that corresponds to the CPT code entered. **The Board prefers that you list only one Anatomy and Category per CPT code. Bilateral Procedures should be entered only once using one CPT code with the .50 modifier (opposite side).** Multiple selections can be made by holding down the “Ctrl” key on your keyboard. Once all information for the CPT code has been entered, click “Save Code.” All the fields will clear and your code will appear under “CPT Code (Description).”
 - ❖ There will be a **pencil icon** to the left of the code so that you can view information entered for that code and edit if necessary. A **garbage can icon** to the right of the code allows a code to be deleted if needed. You may enter in another code after clicking “Save Code” or by clicking “Add CPT Code” to clear any information in the fields.
 - ❖ If you do not know the CPT code for the case, you may use the CPT Coding Tool. Clicking “CPT Coding Tool” will open up a new window where, as you check off anatomy and category classifications, a

list of CPT codes that match your selections will appear. Select the CPT code you wish to use and click the “Add Code” button. A pop-up box will appear letting you know that the code has been added. You can repeat this process for each procedure. Click “Close Window” when you are done and you will return to the case screen. The CPT code(s) entered will appear under “CPT Code (Description).”

- ❖ As you continue to use particular CPT codes, the system will generate “My TOP Procedures” for you. Then, for subsequent cases, you only need to click on the saved CPT code and the Anatomy & Category fields will automatically be completed.
- ❖ *Include all CPT codes plus modifiers used for insurance billing purposes.* CPT codes starting with 99 (evaluation and monitoring codes for office visits, consultations, etc.) are not required. For non-surgical admissions to the hospital, 99 CPT codes can be used.
- ❖ A CPT code frequency field is included so that a CPT code may be entered once with the number of times the procedure was performed (e.g. X2, X3, etc. for multiple skin grafting procedures).
- **To provide an equitable examination for all candidates, no candidate is exempt from CPT coding. Candidates practicing in Managed Care Relationships, Military, Veterans Administration, Kaiser Permanente, Shriners’ Hospitals, Canada and foreign countries must also include CPT codes for all cases.**
- The automatic CPT code descriptors, which appear when a CPT code is entered, are the copyright of the American Medical Association (AMA).

Outcomes and Adverse Events

- If there were adverse events, indicate such in the Outcomes question. Once you click “Adverse Events”, additional fields will appear on the screen allowing you to identify what the adverse events were. A brief description for every adverse event is required in the text box provided.
- Severity of complications are **reported on your case list compilation** as follows:

<u>Major Adverse Events</u>	<u>Moderate Adverse Events</u>	<u>Minor Adverse Events</u>
Unplanned admission	Unplanned Re-op w/o sedation	Seroma requiring drainage
MI, DVT, CVA, PE Unplanned Re-op w/ sedation	Dressing changes > 6 weeks	Hematoma requiring drainage
Infection - IV antibiotic as inpatient	Infection - IV antibiotics	Wound Infection requiring drainage
Adverse drug event Unplanned ED visit	Unplanned consult w/ other specialist	PO antibiotics Dressing changes less than 6 weeks Increased number of office visits
Flap loss		
Prolonged hospital stay		

You can click any of the following buttons located at both the top and bottom of the screen to save your data:

- **Case Log** – Saves any changes and returns user to the case log.
- **Save Case** – Saves any changes and current case remains on screen.
- **New Case** – Saves any changes and allows user to add another case.
- **Log out** – Saves any changes and logs the user out of the system.

We recommend that you log out whenever you leave the site to prevent unauthorized users from accessing your Clinical Case Log data.

Step 5 – Editing/Verifying Case Data

The Clinical Case Log provides several ways for you to filter and sort your case list to ease the task of finding, verifying, and editing data. From the Case Log screen, you will see all of your cases in a list. Cases will be listed as those with incomplete data, and cases that are complete. To complete incomplete cases, **clicking on any item in that row** will take you back to that case form. You can easily identify the missing fields by the red box around them.

- **Sorting the List** – Sort the list by any of the columns displayed simply by clicking on the column heading. Clicking once will sort the list in descending order. Clicking again will sort the list in ascending order.
- **Changing Number of Cases per Page** – By default the system will only display 25 cases per page. You can increase/decrease this number by clicking on the “25 per page” drop-down box and changing the value. You can also scroll through the pages by clicking the forward/backward arrows.

- **Filtering Your Case List** – Use the “All Facilities” drop-down box and the “All Cases” drop-down box to filter your list by these fields. To filter your list even further, click the “Search Cases” link. From this screen you can filter your list by several criteria such as gender, anatomy, category, etc. You can do the same by clicking on Statistics in the main menu. Here you will see a statistical summary of your case list. Many numbers on this report are links that will filter your case list as well.
- **Editing Your Data** – Click on the **pencil icon** to open the case form and edit the data. Once again you can click on the buttons at the top and bottom of the screen to save the data.
- **Deleting a Case** – Click the **garbage can icon** at the right side of a case from the case log to delete a case.

An hourglass icon in the far right column indicates that case data are incomplete. Look for red boxes around required fields.

Step 6 – Finalizing Your Case List – Must be finalized by February 2, 2016.

Once you have verified all of your case data and assured its accuracy, you are now ready to finalize your case list. From the case log screen, click the “**Finalize Case List**” link, identified by the key icon (**Must be in “Hand Mode”**). Once you finalize your case list, you will no longer be able to edit your case information. If you discover an error in your case list after you have finalized, please contact the Board Office at 215-587-9322.

Step 7 – Saving a Copy of Your Case List (Recommended)

You do not need to submit a hard copy of your case list to the Board Office. However, the Board recommends that

diplomates retain a an electronic copy of the list with statistics page for future reference for society membership or other purposes. The “Print Cases” Screen appears after clicking “Finalize Case List.” Or you can click the “Print Case List” link in the main menu.

TIP: Select “Save to Desktop” option to improve speed and ease of printing. This allows you to keep a copy on your computer and to print from your computer rather than from your browser and the website. In addition, you can also print/save your **Statistical Summary Report**. Click on “Statistics” in the main menu and then “Printer Friendly Version.” Please note, this link will only appear after your case list is finalized.

Step 8 – Submitting Material to the Board Office

Refer to Step 6. Be sure to finalize the case list by February 2, 2016. The online Application, Registration Fee and other required documents uploaded as PDF files must also be finalized on the Board’s website, www.abplasticsurgery.org, by February 2, 2016. See Application Cover letter for details.

All inquiries regarding Hand Subspecialty Certification should be addressed to the Board Office (hand@abplasticsurgery.org or 215-587-9322).

SAMPLES OF CLINICAL CASE LOG SCREENS

INITIAL LOG IN SCREEN



**The American Board
of Plastic Surgery, inc.**

ATTN: 2016 HSC Diplomates: The deadline for case collection is February 2, 2016

User Name:

Password:

[I forgot my password](#)

Note: This site is best used with Internet Explorer.
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- ❖ **LOG IN TO YOUR PHYSICIAN PROFILE ON THE BOARD'S WEBSITE TO ACCESS THE CLINICAL CASE LOG LINK ON THE HAND TAB**
- ❖ **THE URL FOR THE CLINICAL CASE LOG SIGN-IN SCREEN ABOVE IS:**

<https://secure.dataharborsolutions.com/clinicalcaselog>

- ❖ **LOG IN USING YOUR USERNAME AND PASSWORD**

🔑 Your default username is your six-digit Board ID number.
Your default password is your last name (case sensitive, with the first letter capitalized, e.g. Smith). You may change this at any time.

🔑 If you previously customized your username and password by registering on the Board's website, you will log in to the Clinical Case Log with the same username and password you created.

CLINICAL CASE LOG PROFILE SCREEN

Edit User [SMITH, JOHN]

First Name	Middle Name	Last Name	Suffix
<input type="text" value="John"/>	<input type="text" value="A"/>	<input type="text" value="Smith"/>	<input type="text"/>

Email Address


Training State

User Name

Password

Confirm Password

Click on the "Add Facility" button to add facilities where you have surgical privileges...

Facilities  [Add Facility](#)

- [Surgery Center](#)
- [NWCH](#)
- [Doctor's Office](#)
- [Surgery Center](#)
- [Test Hospital](#)
- [New Facility](#)
- [Hospital](#)
- [Cottage Hospital](#)
- [My Facility](#)

- ❖ **PLASTIC SUGERY TRAINING STATE MUST BE ENTERED**
- ❖ **START OF TRACKING DATE MUST BE ENTERED**
- ❖ **CASE LIST MUST BE 15 CONSECUTIVE MONTHS WITHIN TWO YEARS PRECEDING SUBMISSION OF APPLICATION MATERIAL**

ADD FACILITY SCREEN

Facilities for User [AUser, ATest]

New Facility ▾

Facility Name

Facility Zipcode

Facility Type

Admission Type(s) ☐ Inpatient ☐ Outpatient ☐ Both

What is your level of credentialing at this facility?

Office Surgery Center Accreditation Type



Office Surgery Center Accreditation Program


☐ 1. AAAASF ☐ 2. AAAHC ☐ 3. JCAHO

☐ 4. Medicare Certification ☐ 5. State Licensure ☐ 6. Other:

❖ **FACILITY TYPE SOMETIMES FILLS THE
ADMISSION TYPES**

CASE LOG SCREEN









 [Click here to add a case...](#)
 [Finalize Case List](#)

<< 1 thru 2 25 per page >>
 [Search Cases](#)
[Reset](#)


02/02/2016


All Facilities
All Cases


Case Count: 2 Case(s)


Case #	Patient Name	Record #	Facility	Date of Surgery	Edit Date	Status
 900006	Smith, Sue	19283	St. Mary's	02/21/08	11/17/09 10:18AM	  
 899981	Harris, Mary	123456	test	03/18/08	11/17/09 10:18AM	  


Legend


 = Add Case


 = Edit Case


 = Delete Case

 = Copy Case

 = Finalize Case List

 = Search Cases

 = Required Fields Completed

 = Incomplete

- ❖ **CLICK ON PENCIL ICON TO EDIT AN ENTERED CASE**
- ❖ **RED CHECK BOX DENOTES ALL DATA FIELDS COMPLETE**
- ❖ **FINALIZE “KEY” LINK WILL APPEAR IN THE TOP RIGHT CORNER**

MENU OPTIONS

Menu

Profile

Go Mode Hand

Case Log

Print Cases

Print Forms

Reports

Statistics

Instructions

Requirements

FAQ

Contact Info

Suggestions




Logout

- ❖ **CLICK “GO MODE ALL” TO VIEW ALL CASES ENTERED**
- ❖ **CLICK “GO MODE HAND” TO VIEW ONLY CASES ENTERED WITHIN THE HAND COLLECTION PERIOD**

CASE DATA FIELDS

Please check one answer per question unless otherwise indicated. Required fields have an asterisk (*).

Incomplete required fields are boxed.

* Patient First Name	* Last	* Medical Record #
Michael	Smith	789
(Visible to physician only; initials visible to ABPS)		
* Birth Date	* Patient Gender	
04 / 05 / 66 (mm/dd/yy)	<input checked="" type="radio"/> 1. Male <input type="radio"/> 2. Female	
(Age, not DOB, prints on the Case List)		
* Hospital/Facility Name	* Admission	
University Medical Center   Edit Facility	<input type="radio"/> 1. Inpatient <input checked="" type="radio"/> 2. Outpatient	
* Procedure Date Make Today	* Procedure Duration	
03 / 31 / 09  (mm/dd/yy)	1 : 00 (hours & minutes, skin-to-skin, excluding anesthesia time)	
* Diagnosis Description		
cysts		
* Procedure Description		
acne surgery		

- ❖ RED BOXES DENOTE INCOMPLETE FIELDS
- ❖ DIAGNOSIS DESCRIPTION AND PROCEDURE DESCRIPTION ARE FREE TEXT FIELDS. USE THESE FOR EXPLANATIONS OR SPECIAL NOTATIONS.
- ❖ ICD 9 CODES ARE NOT NEEDED

CPT FIELD AND CLASSIFICATION

Add CPT Code

CPT Code (Description)
 20103 (Exploration of penetrating wound (separate procedure); extremity)

* CPT Code	Modifiers	# Times
20103		

In order for a procedure to qualify for inclusion in the case list for certification in the Subspecialty of Surgery of the Hand (SOTH), please be sure to select Hand under Category Classification if a procedure was performed on the upper extremity distal to the elbow.

*** Anatomy Classification**
(Select all that apply.)

- ☐ 1. Breast
- ☒ 2. Hand/Upper Extremity
- ☐ 3. Head and Neck
- ☐ 4. Lower Extremity
- ☐ 5. Trunk/Genitalia

*** Category Classification**
(Select all that apply.)

- ☐ 1. Congenital
- ☐ 2. Cosmetic
- ☐ 3. General/Reconstructive surgery
- ☒ 4. Hand
- ☐ 5. Skin (including skin cancer)
- ☐ 6. Trauma
- ☐ 7. Nonoperative/Other

*** Hand Sub-Category**
(Select all that apply.)

- ☐ 1. Bone and Joint
- ☐ 2. Nerve
- ☐ 3. Tendon and Muscle
- ☒ 4. Skin and Wound Problems
- ☐ 5. Contracture and Joint Stiffness
- ☐ 6. Tumor
- ☐ 7. Congenital
- ☐ 8. Microsurgery Vascular
- ☐ 9. Nonoperative

Save Code

- ❖ **SELECT ANATOMY AND CATEGORY FOR EACH CPT CODE**
- ❖ **HAND SUB-CATEGORIES ONLY APPEAR ONCE HAND IS SELECTED**
- ❖ **MINIMUM # OF CASES MUST BE MET IN 5 OF 9 REQUIRED CATEGORIES**

CPT CODING TOOL & MY TOP PROCEDURES

* **Procedure Code(s)** Add all CPT Codes that apply.



Enter code information below, then click 'Add Code'. To add more than one code, repeat the process.
When finished, click on the 'Close Window' button.

Select anatomy and classification, then click on a code from the list at the bottom of the window, or type in the code.
[Reset](#) (Click on 'Reset' to start over.)

Anatomy (Check all that apply.)

<input type="checkbox"/> 1. Breast	<input checked="" type="checkbox"/> 2. Hand/Upper Extremity	<input type="checkbox"/> 3. Head and Neck
<input type="checkbox"/> 4. Lower Extremity	<input type="checkbox"/> 5. Trunk/Gentalia	

Classification (Check all that apply.)

<input type="checkbox"/> 1. Congenital	<input type="checkbox"/> 2. Cosmetic
<input type="checkbox"/> 3. General/Reconstructive surgery	<input checked="" type="checkbox"/> 4. Hand
<input type="checkbox"/> 5. Skin (including skin cancer)	<input type="checkbox"/> 6. Trauma
<input type="checkbox"/> 7. Nonoperative/Other	

My Top Procedures (Click on a row below for a quick selection of your common code information. Hover over a row to get a description.)

25109 [Hand/Upper Extremity] [Hand]
20816 [Hand/Upper Extremity] [Hand]
20103 [Hand/Upper Extremity] [Hand]
10060 [Hand/Upper Extremity]
10049 [Head and Neck]
10021 [Hand/Upper Extremity] [Hand]
10021 [Hand/Upper Extremity]

CPT Code **Modifiers** **# Times**

[Add Code](#)

10021 - FNA W/O IMAGE
10022 - FNA W/IMAGE
15241 - Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and...
16035 - Escharotomy
16036 - NCSE BURR SCAB, ADDL, NCIS
20103 - Exploration of penetrating wound (separate procedure), extremity

- ❖ **CLICK CPT CODING TOOL LINK**
- ❖ **SELECT ANATOMY AND CATEGORY TO PRODUCE A LIST OF CPT CODES**

OUTCOMES

*** Outcome 30 days Post op**
☒ 1. No Adverse Events ☐ 2. Outcome unknown ☐ 3. Adverse Events (Check all that apply below)

Delayed healing <input type="checkbox"/> Increased number of office visits <input type="checkbox"/> Dressing changes less than 6 weeks <input type="checkbox"/> Dressing changes greater than 6 weeks	Infection <input type="checkbox"/> PO antibiotics <input type="checkbox"/> IV antibiotics as outpatient <input type="checkbox"/> IV antibiotics as inpatient	Unplanned consultation with other specialist <input type="checkbox"/> Infectious disease <input type="checkbox"/> Neurologist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Vascular <input type="checkbox"/> Other specialist
Puncture or laceration to other body organ or structure <input type="checkbox"/> Which organ or structure? <input style="width: 150px;" type="text"/>		
Adverse event <input type="checkbox"/> Adverse drug event <input type="checkbox"/> DVT <input type="checkbox"/> MI <input type="checkbox"/> PE <input type="checkbox"/> CVA <input type="checkbox"/> Flap loss		
Drainage <input type="checkbox"/> Seroma requiring drainage <input type="checkbox"/> Hematoma requiring drainage <input type="checkbox"/> Wound infection requiring drainage	Unplanned re-operation <input type="checkbox"/> Without need for IV sedation or anesthesiologist <input type="checkbox"/> With need for IV sedation or anesthesiologist	Unplanned hospital stay <input type="checkbox"/> Unplanned admission <input type="checkbox"/> Unplanned emergency department visit <input type="checkbox"/> Prolonged hospital stay (longer than planned)
Other Adverse Event <input type="checkbox"/> Explain: <input style="width: 150px;" type="text"/>		

*** Mortality within 30 days of procedure**
☐ 1. Yes ☒ 2. No

- ❖ IF “NO ADVERSE EVENTS” CLICKED THEN BREAK OUT SCREENS DO NOT APPEAR
- ❖ “MORTALITY WITHIN 30 DAYS OF PROCEDURE” IS A REQUIRED FIELD EVEN IF “NO ADVERSE EVENTS” IS SELECTED (SOME REDUNDANCY IS BUILT IN)
- ❖ IT IS UNDERSTOOD THAT “MORTALITY WITHIN 30 DAYS OF PROCEDURE” CAN’T BE KNOWN FOR CASES COMPLETED LESS THAN 30 DAYS FROM THE SUBMISSION DEADLINE OF 2-2-16.

STATISTICS REPORT (1 of 2 PAGES)

Statistics for Michael Smith

(01/20/2016))

This information is protected by the Medical Studies Act of the State of Illinois

Case Count Distribution

	Count	Age (years)		Duration of Surgery (minutes)	
		Average	Std. Dev.	Average	Std. Dev.
Male	<u>4</u> (6%)	46.6	10	83	56
Female	<u>60</u> (94%)	45.1	12	144	73
Total	<u>64</u>	45.2	12	140	74

CPT Codes

	Total Codes	Codes Per Case	Distinct Codes
Valerie Ablaza	104	1.6	30

Case Count By Outcome

	Count	%
Unknown Adverse Events	<u>0</u>	0%
No Adverse Events	<u>60</u>	94%
Minor Adverse Events	<u>1</u>	2%
Moderate Adverse Events	<u>0</u>	0%
Major Adverse Events	<u>0</u>	0%
Patient Died	<u>0</u>	0%
Other	<u>3</u>	5%

Case Count By Institution

	Count	%
North Fullerton Surgery Center	<u>57</u>	89%
Saint Barnabas Medical Center	<u>7</u>	11%

Case Count By Admission Status

	Count	%
Inpatient	<u>3</u>	5%
Outpatient	<u>61</u>	95%

Category Counts

	Count	%
Congenital	1	2%
Cosmetic	52	81%
General/Reconstructive surgery	13	20%
Hand	0	0%
Skin (including skin cancer)	2	3%
Trauma	0	0%
Nonoperative/Other	0	0%
Total	68	

Anatomy Counts

	Count	%
Breast	38	59%
Hand/Upper Extremity	2	3%
Head and Neck	17	27%
Lower Extremity	9	14%
Trunk/Genitalia	15	23%
Total	81	

Anatomy By Category (Procedural Counts)

(More than one anatomy and/or category classification may have been selected for an individual procedure.)

	Anatomy					Total
	Breast	Hand/Upper Extremity	Head and Neck	Lower Extremity	Trunk/Genitalia	
Congenital	1	0	0	0	0	1
Cosmetic	28	2	27	9	17	83
General/Reconstructive surgery	24	0	0	0	0	24
Hand	0	0	0	0	0	0
Skin (including skin cancer)	0	0	3	0	0	3
Trauma	0	0	0	0	0	0
Nonoperative/Other	0	0	0	0	0	0
Total	53	2	30	9	17	111

Category Counts

	Count	%
Bone and Joint	1	50%
Nerve	1	50%
Tendon and Muscle	1	50%
Skin and Wound Problems	0	0%
Contracture and Joint Stiffness	1	50%
Tumor	0	0%
Congenital	0	0%
Microsurgery Vascular	0	0%
Nonoperative	0	0%
Total	4	

Frequently Asked Questions (FAQ's)

Q.1 Why am I receiving a message when trying to enter a new case that the surgery date is not valid?

A.1 You must first enter your case collection start date for your 15-month case list in your profile screen. The case collection period must be at least 15 months within the two years preceding the application deadline date. Surgery dates outside of this range will not be accepted during the data entry process.

Q.2 **What if there is information that I feel is pertinent to the case but there isn't a place to record it on the case screen?**

A.2 If a case needs some added explanation, the diagnosis and procedure description sections are free text areas where additional information can be provided. A text box is also provided for additional description of adverse events. For example, infection later than six weeks occurred.

TIP/Advice:

Take some time to enter cases each week rather than at the deadline date.

Q.3 **What do the hourglass and red checkmark notations in the status column mean?**

A.3 The hourglass icon indicates that a required field has not been completed for that particular case. Click the pencil icon to the left of the case number to open the form. The incomplete data fields will be outlined with red boxes. CPT code Anatomy & Category

Classifications are often overlooked. All required data must be entered in order to finalize the case list. When a case is complete, the status column on the case log will update to a red checkmark.

Q.4 Should all modifiers be entered manually into the “Modifiers” field in the CPT coding tool?

A.4 Yes. Modifiers should be entered manually in the “modifiers” field. The CPT code box will only accept the 5-digit number then tab to the “modifiers” box to key in the .50 or .51.

Q.5 Does the “number of times” field need to be completed with the value of “2” for bilateral procedures appended with the .50 modifier?

A.5 If a bilateral modifier is used, then do not enter a “2” in the quantity field. That is for multiple procedures on the same area, e.g. multiple wound closures in a trauma case where many lacerations were located anatomically in the same area.

Q.6 A billing office handles my CPT coding – should cases be coded how I think they should be coded, or in the actual manner that the billing office coded the case?

A.6 All CPT codes should be entered exactly as they were billed. It is assumed that how cases were actually billed with CPT coding was the same as the surgeon would have coded. Whether a surgeon’s billing is outsourced or completed in-house, the surgeon’s provider number is used and therefore the surgeon is ultimately responsible for the manner in which the billing was submitted to the third party payers.

Q.7 Since the case list will not print without required fields entered, what is the proper procedure for recently performed cases in regard to the 4-6 wk. adverse events field or the 30 day mortality?

A.7 Enter the Adverse Events as known at the time of the submission. The Board understands this time constraint.

Q.8 How do I apply the Anatomy and Category Classifications in the CPT coding? I still have a red box around the CPT code.

A.8 If a red box surrounds the CPT code, then click on the pencil icon next to the CPT code and go to the boxes below to select an anatomy and category classification. They are not automatically selected for you. Be sure to click “Save code” to save the classification selections.

Q.9 What if I cannot find a CPT code for a procedure?

A.9 Use the CPT coding tool in the clinical log. Selecting the anatomy and category will generate a list of applicable CPT codes. A colleague or training program office may also provide some guidance in this area. Also, ASPS publishes a “CPT Code Corner” article every month in *Plastic Surgery News* that may be of some assistance. The Board Staff does not have the expertise to advise anyone regarding selection of specific CPT codes.

Q.10 There is a “non-operative” category. What type of case would be an example of that?

A.10 Complex wounds managed without operation is a perfect example of the non-operative category.

Q.11 In trying to enter the CPT code for debridement of necrotizing fasciitis (11006), I get a “not valid” message even though it is a valid code.

A.11 If this occurs, try putting in a similar code and note the correct code in the text area of the procedure description.

Q.12 Why do the stats sheets and case lists for certain facilities take so long to appear on the screen?

A.12 The compilation of the lists and stats sheet for printing demands a great deal of processor time. Allow a few minutes for those reports to load on your screen. Remember to save your case list to your computer for your own reference.

Q.13 How do I list inpatient non-surgical admissions, for example, cellulitis?

A.13 Enter the day of admission or discharge as the “operation date.” You can use Evaluation and Monitoring Codes (99...) as the CPT code for that type of case.

Q.14 Where do I get answers to my questions about data entry, the Clinical Case Log program, Board requirements or printing, etc.?

A.14 1. Take time to review the Board’s materials – most answers are there. 2. Instructions and Requirements are accessible in the Clinical Case Log Menu. 3. Email questions to Web Data Solutions (WDS) at support@dataharborsolutions.com. 4. Email the Board at hand@abplasticsurgery.org. 5. Call Web Data Solutions technical support at 312-944-0642. 6. Call the Board Office at 215-587-9322.

Q.15 I entered cases and now can't see them on my case list. What do I do?

A.15 Make sure you are viewing "250 cases per page" – see the drop down box at the top of your case log screen.

Q.16 Why is the system slow?

A.16 The viewing and printing of case lists and statistics sheets creates a very high demand on processor speed at Web Data Solutions' servers. This is especially true the week before a deadline date. Even with upgraded servers, with twice the speed and memory, this function may still be slower at high peak times. We suggest you save the case list on your desktop or somewhere on your own computer, then print from your computer rather than from the Clinical Case Log website and your browser.

Q.17 Why am I unable to see the information (Cases, CPT codes, etc.) that has just been entered?

A.17 This issue is caused by the way the individual's Internet Explorer or other browser is set up to update cached pages. The pages viewed in the browser are stored so that the page loads quickly the next time the webpage is visited. If the browsers are not set up to get updated pages from the server, only the old page is displayed. This is the origin of the problem. As users update cases, the browser is still showing the old page that is stored on the individual's computer rather than obtaining the new, updated pages from the server. The answer below is how Tech Support advises users to set up Internet Explorer:

If you are using Internet Explorer, please ensure that the browser is set to receive new pages from the server

automatically. To do this, in Internet Explorer, click on Tools, Internet Options. On the “General” tab in the “temporary internet files” section, click on “Settings.” Make sure that the “check for newer version of stored pages” is set to “automatically.”

Q.18 I have two procedures for one case and they are classified differently, will both procedures count towards the minimum anatomy and category classifications?

A.18 Multiple procedures within a case will be counted toward satisfying the one (1) case minimum for anatomy and category classification requirements.

Complex operative management represents a more substantial surgical operative experience than a less complex single task surgery. A complex injury is defined as those cases which involve several of the nine categories in addition to the skin/wound category. Therefore, in an injury involving the volar wrist, multiple tendons and the median nerve would ‘count’ as two categories, tendon and nerve – but not additionally for the skin closure. Further, no single operative case would be allowed to count for more than three categories towards the requirement of 125 cases.

For example, the management of a complex mutilating injury involving repair of muscle, tendon, nerve, vascular injury, and skin would count for tendon and muscle, nerve, and microsurgery vascular, but not for the skin. This example clearly indicates a more complex operative experience than a simple, single task surgery. Those cases in which the involvement of two categories is part of a single focus surgery, such as the use of a tendon in ligament reconstruction and tendon

interposition of the basal joint, would continue to count as only one case.

Q.19 The ASSH is requesting the “cover sheet” from my case list for membership application requirements. Where do I find this document?

A.19 The statistics page generated by the Clinical Case Log after finalization of your case list is sufficient for this requirement. The statistics page is accessible in the main menu from the “Go Mode Hand” screen once logged into your case log.

END FAQ's

NOTES

NOTES

NOTES

HAND SURGERY EXAMINATION FEES

Application Registration Fee (Payable with Online Application and is non-refundable.)	\$ 405.00
Application Registration Late Fee	\$ 160.00
Hand Surgery Examination Fee (Payable with Online Reply Form)	\$1,240.00
Late Penalty Fee	\$ 250.00
Withdrawal Fee	\$ 520.00
Missing Items Penalty Fee	\$ 120.00
Credential Review Fee	\$ 280.00
Ethics Review Fee	\$ 280.00
Additional Certificate Fee	\$ 145.00
Verification of Status Fee	\$ 50.00
Checks Returned for Insufficient Funds Charge	\$ 65.00
Photocopying Fee	\$ 30.00

- ❖ Application and Examination Fees must be submitted by credit card only. Foreign currencies, including Canadian, are unacceptable. Select other fees acceptable by check only. Fees are non-refundable.
- ❖ Fees are subject to change by the Board. The fee schedule applicable to the current examination will apply regardless of when the Diplomate is approved for admission to examination.
- ❖ The Board is a nonprofit organization, and the fees of Diplomates are used solely for defraying the actual expenses of the Board. The Directors of the Board serve without remuneration.

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