

# PREPARATION OF LOGS: CLINICAL EXAMINATION

*American  
Osteopathic Board of  
Orthopedic Surgery*

## I. COMPUTER DISK FORMAT

All logs must be submitted as printed logs and on a CD. You must use the Excel format established by the AOBOS. This Excel format is available on the AOBOS web site [www.aobos.org](http://www.aobos.org)

From the AOBOS home page, click on the Certification tab.



**ONLINE APPLICATION FORMS**

The following forms from the Handbook for Candidates for Board Certification may be filled out and sent to the [AOBOS](http://www.aobos.org).

- [Application for Written Examination](#)
- [Application for Oral Examination](#)
- [Application for Clinical Examination](#)
- [Preparation of Logs](#)
- [Change of Address](#)

[Tutorial Application](#)

Unzip the file using WinZIP (or another file compression utility), and double-click "Runtest.bat" to run the tutorial.

- [Clinical Exam Log](#)

Right-click and select "Save Target As", complete the log and e-mail the final result to [AOBOS](http://www.aobos.org).

Scroll down the certification page until you see the On-Line Application Forms on the left of the screen; choose the Clinical Exam Log Template. Save this Excel file as your template for surgical log entry.

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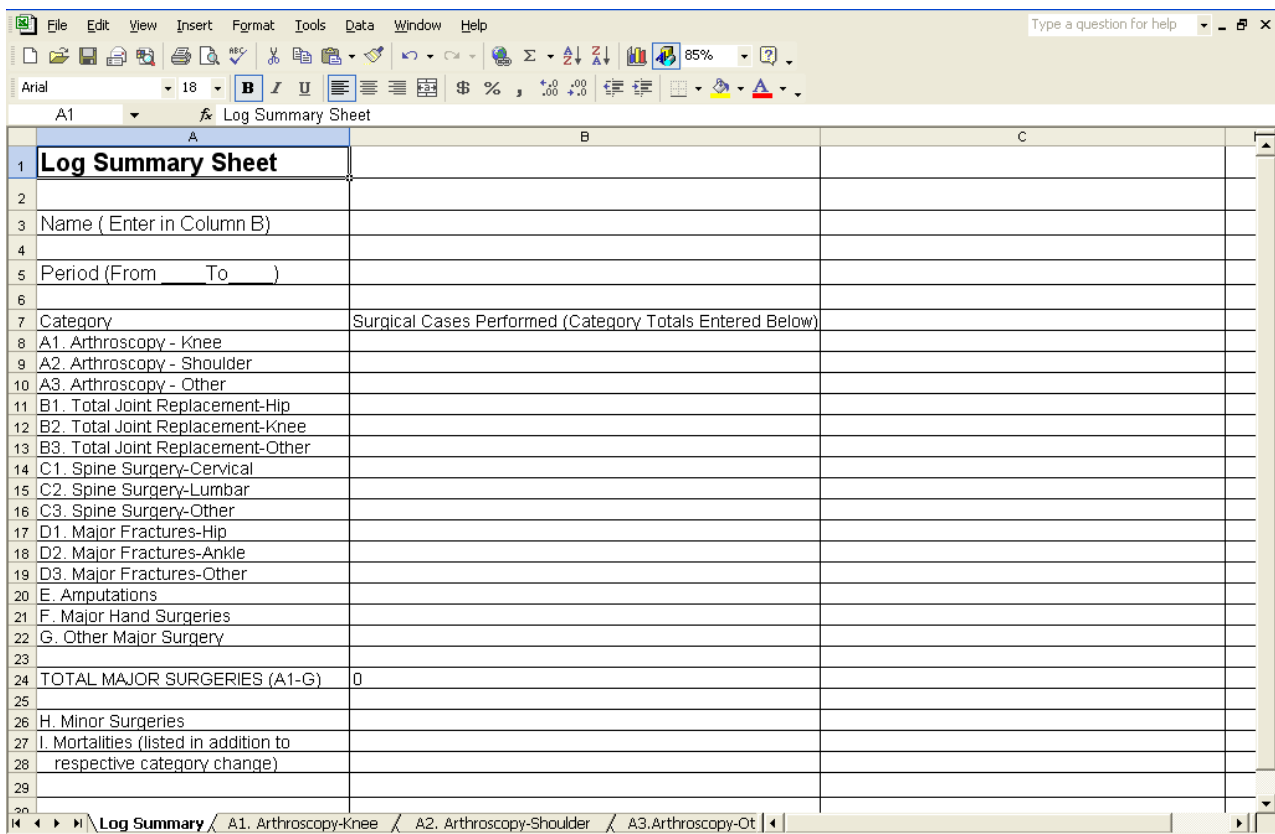
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The first worksheet visible in the Excel file is the Log Summary Sheet, as displayed below. The following format is to be followed for the submission of surgical cases. No independent format may be substituted. No alternate categories may be used.

Enter your name in cell B3 on this form and the beginning and ending dates for your surgical log entry in cell B5. When finished entering your surgical log data in the appropriate categories, enter the number of cases for each category in column B on this worksheet.



At the bottom of the Excel log file, you will find tabs for each of the categories required for your surgical logs. When you click on the tab, you will move to that category's log sheet.

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A sample of the *A1. Arthroscopy – Knee* log is displayed below.

	A	B	C	D	E	F	G	H	I
1	<b>A1. Arthroscopy-Knee</b>							0	
2	<b>list #</b>	<b>date</b>	<b>hospital</b>	<b>case #</b>	<b>P.I.</b>	<b>Age</b>	<b>Diagnosis</b>	<b>Operative Procedure</b>	<b>Complications &amp; Outcome</b>
3	1								
4	2								
5	3								
6	4								
7	5								
8	6								
9	7								
10	8								
11	9								
12	10								
13	11								
14	12								
15	13								
16	14								
17	15								
18	etc								
19									
20									
21									
22									
23									
24									



Using the navigation icons at the bottom of the screen, you can move to all of the 17 required surgical log categories. Only a portion of the available categories tabs will display on the screen at any given time.

The first icon  moves the listed tabs to first worksheet in the surgical log template file, the last icon  moves the listed tabs to the last category – Mortalities. Clicking the  moves your category listings one category toward the beginning of the log, and clicking on the  moves your tab listings one category toward the end of the surgical log. Once the desired category tab is visible across the bottom of the screen, clicking on that tab will move you to that category’s worksheet.

Within each category, you must:

1. List the cases chronologically.
2. Number your cases 1 to x separately for EACH category. Do NOT simply number your entire log 1 to x.

A sample log for the *A1. Arthroscopy – Knee* is listed on the following page.

A1. Arthroscopy-Knee							Candidate Name	
list #	date	hospital	case #	P.I.	Age	Diagnosis	Operative Procedure	Complications & Outcome
1	1/12/2004	LSC	12367890	DKM	22	Tear medial meniscus Left knee	scope medial menisctomy left knee	
2	1/15/2004	LSC	12389012	SWQ	27	Tear medial miniscus Left knee	scope medial menisctomy left knee	
3	1/17/2004	LSC	12390123	HTF	31	Tear lateral & medial meniscus Rt knee	scope medial and lateral menisectomy rt knee	
4	1/17/2004	LSC	12391123	JKU	26	Tear medial meniscus and ACL left knee	scope medial menisectomy left knee, ACL reconstruction B-T0B allograft	
5	1/19/2004	LSC	12400121	TAM	16	Chronic lateral tracking rt patella	scope lateral retinacular release rt knee	
6	1/30/2004	LSC	12400245	EWS	18	Tear meidal meniscus Left knee	scope medial menisctomy left knee	
7	2/2/2004	LSC	12400345	HGT	27	Tear right ACL	scope hamstring tendon ACL reconstruction rt knee	
8	2/26/2004	LSC	12431189	FTR	65	Tear medial meniscus Left knee; djd MFC	scope medial menisectomy left knee, chondroplasty medial femoral condyle	Post op DVT. Admitted for heparinization. Discharge in 3 days. Recovered uneventfully.
9	3/1/2004	LSC	12481190	DGJ	21	Bucket handle tear medial meniscus rt knee	scope medial meniscus rt knee	
10	3/4/2004	LSC	12500121	GBI	65	Tear medial and lateral meniscus rt knee	scope medial/lateral menisectomy rt knee	
11	4/1/2004	ACH	290-090	ITD	67	Septic Arthritis left knee	scope irrigation, synovectomy, insertion of in flow outflow drains left knee	
12	4/4/2004	ACH	290-290	ITD	67	Septic Arthritis left knee	scope, synovectomy left knee	

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## II. SUBMISSION OF SURGICAL LOGS

You must count all patient contacts from the time you begin your log until the ending date prior to submission. A patient contact is any treatment provided in the Hospital, Out Patient Surgery Facility, Office or any other institution. Any patient that falls into one of the listed categories must be recorded and documented in your surgical logs. Routine office visits and non-surgical patient consults and treatments do not need to be recorded. ALL other patient contacts fall into one of the categories A-H and therefore will be listed in your logs.

Mortalities are to be listed both in the category of primary treatment and under Category I (Mortalities). **Mortalities apply to deaths that occur within 30 days of the surgical procedure.** All mortalities require a summary report to be personally authored by the candidate and be submitted as part of the documentation necessary for the Clinical Exam application. (See Mortality Review on page 41.)

To be considered for Part III – Clinical Examination, a minimum of 200 **MAJOR** patient surgeries must be documented. This is a minimum number of cases and should be exceeded in all but rare instances. You must document no less than 12 consecutive calendar months and no more than 24 consecutive calendar months in the surgical log. These should be the most recent months just prior to your application for the exam. The 200 case requirement must be from a single geographic location. Any variations to the single geographic location requirement must be formally requested and approved by the AOBOS Board.

All cases must be recorded during the time period. It is not appropriate to omit or exclude from the count any MAJOR or MINOR case during this time period.

## III. MAJOR VS. MINOR CASES

The AOBOS uses the criteria established in the RBRVS, *Resource Based Relative Value Scale* (the physician payment schedule for Medicare) for what constitutes major vs. minor cases. Use the RBRVS (*Resource Based Relative Value Scale*) to look up the code in question. If it has a 90 day follow-up, the case is considered major. If it has a 0-10 day follow-up, the case is considered minor.

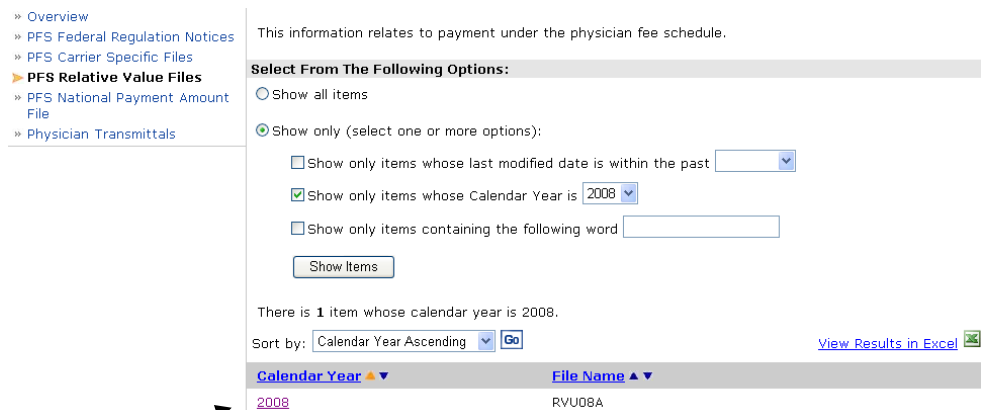
If you do not have access to the RBRVS code book, you can order one at <http://www.codingbooks.com> or you can access the Medicare website <http://www.cms.hhs.gov/PhysicianFeeSched> and look in the Physician Fee Schedule section.

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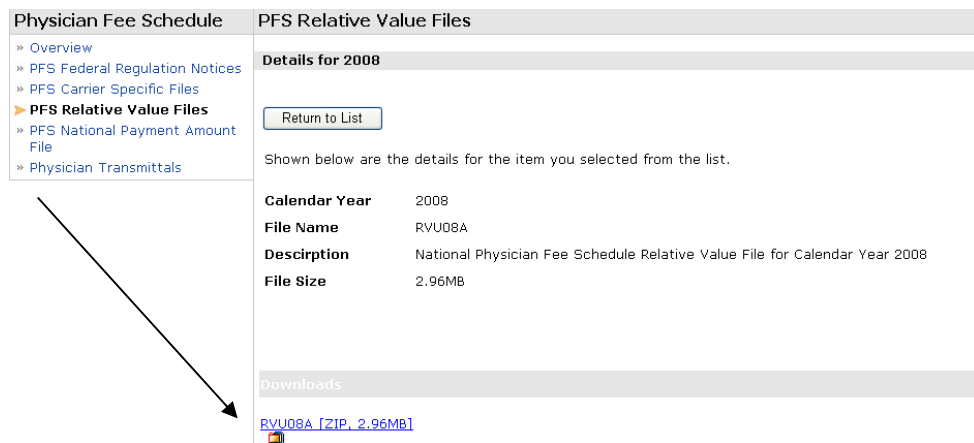
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- Choose the PFS Relative Value Files. (On the left hand side of the screen.)
- The following screen will appear. In the Show only section, check the box for Show only items whose Calendar Year is; and choose the current year from the drop down box, as indicated in the example below.



- At the bottom of the screen, choose the most recent revision file by clicking on the Calendar Year and File Name line.
- In the Downloads section of the screen, click on the RVU... zip file name.



- Choose Save to save the Physician Fee Schedule as an Excel table.
- Select a location on your computer to save the information (i.e. your desktop)
- Click on Open
- Open the PPRRVU...  (not the "a" format ) spreadsheet.
- Look for the global days column
  - 000-010 = minor

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- 090 = major
- XXX = global does not apply
- ZZZ = use global days from another service code that this is related to

## IV. CASES VS. PROCEDURES

The log is intended to report “cases”, not necessarily procedures. A “case” is a patient contact or encounter, for which multiple surgeries or procedures may have been performed. You must choose the primary procedure you want to include in your log and submit it in the appropriate category. The other procedures from that “case” can be optionally listed with the primary procedure, to indicate other work was done, but only the primary procedure is tallied in the category.

For example, you might have repaired flexor tendons and digital nerves at the same setting, accounting for multiple “procedures”. However, you must choose which procedure you want to log, i.e. either flexor tendon repair or digital nerve repair, and cannot list them separately.

## V. CLINIC CASES

If you are practicing in a Residency Training Program where you supervise the clinic run by the residents who perform the procedures and manage care of patients from that clinic, you have the option of excluding these cases from your log. If you choose to include them, you will be held to the same standard of participation as expected in the rest of your cases including evidence that the paper work is done by you. **ALL REPORTS MUST BE AUTHORED BY THE CANDIDATE!!**

## VI. CHART DOCUMENTATION

As you prepare for your clinical examination, chart documentation remains an important part of the Chart Review portion of your exam. Twenty charts from your surgical logs will be reviewed in detail. Poor chart mechanics will have a significant impact on this segment of your clinical examination. The following guidelines are provided to aid you in two of the chart mechanics areas.

Following Medicare guidelines:

An H&P **must** be performed no more than 30 days prior to admission and updated the day before or day of surgery. Office medical records that substantiate the hospitalization or procedure should be part of the inpatient record. Medicare requires that the hospital medical record justify the admission and treatment.

Discharge summaries should be dictated as soon as possible after discharge. If unable to dictate on the day of discharge, write a final summarizing progress note to include:

1. Principal diagnosis, secondary diagnoses and principal procedure.
2. Brief description of the hospitalization, disposition of the case, and follow-up care.
3. Results of diagnostic testing that confirm the principal diagnosis.