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| --- | --- | --- | --- | --- | --- | --- |
| 1 | | vhabps  vhabpd | Enter the patient’s most recent blood pressure documented in the VHA medical record within the past year.  (Exclude BP taken in ED, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission) | \_\_ \_\_ \_\_  /\_\_ \_\_ \_\_  **Abstractor can enter zzz/zzz if no blood pressure was taken at any applicable VHA outpatient encounter within the past year**  If vhabp z-filled, auto-fill bp1dt as 99/99/9999, and go to encarcor   |  | | --- | | Warning if vhabps <= 80 or > = 250  Warning if vhabpd < = 44 or > = 135  Hard edit: vhabps and vhabpd must be > 0  Hard edit: vhabps must be > than vhabpd | | **Acceptable for BP measurement:**  **1) BP taken by ancillary personnel. The individual taking the BP does not have to be one of the designated clinicians.**  **2) BP measurement report documented in the VHA medical record (scanned report) from an outside provider or professional entities (e.g, Health Departments) is acceptable.**  **3) BP measurement obtained from outside provider or professional entity documented in a clinic note by a licensed member of the healthcare team with the date the BP was measured.**  **4) BP recorded by HBPC**  If there are multiple BPs recorded for a single date at acceptable VHA outpatient encounters, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. For example, patient was seen in primary care clinic and cardiology clinic on 12/22/20XX. Two BP measurements were noted - 148/82 and 138/92. Enter 138/82 as the lowest BP recorded for that date.  **NOTE: Do not enter electronic capture of BP documented by Care Coordination (CC/H) as it will be entered in a subsequent question.**  **EXCLUDE the following BP readings:**   * Blood pressure taken in the Emergency Department, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission. An Urgent Care clinic is not to be confused with a walk-in, non-urgent clinic (same day care clinic available at some facilities.) If the blood pressure taken in the ED or at an Urgent Care clinic is the patient’s only BP taken within the past year, enter zzz/zzz. * Patient self-report of BP in person or via phone conversation is not acceptable (e.g., nurse documents, “Patient called. BP today 120/78). * BPs taken during an outpatient visit which was for the **sole** purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) * BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)   **If blood pressure was not taken at an accepted VHA encounter or documented in the VHA medical record within the past year, enter default zzz/zzz.** |
| 2 | | bp1dt | Enter the date this blood pressure was measured. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if vhabp  z-filled   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.  If VHABPS and VHABPD were z-filled, the date will auto-fill as 99/99/9999. The abstractor cannot enter the 99/99/9999 default date if valid BP numbers were entered in VHABPS and VHABPD. |
| 3 | | encarcor | Is there documentation the patient was enrolled in Care Coordination (CC/H)?  1. Yes  2. No | 1,2  If 1, go to ccbps  If 2, auto-fill ccbps as zzz/zzz, ccbpdt as 99/99/9999, and go to scibps as applicable | **Care Coordination (CC/H) electronic capture of BP**: Patient measures his BP and the readings are electronically transmitted to Care Coordination. This BP reading **cannot** be changed by the patient and does not involve patient interpretation.  The BP readings are entered into the legal medical record by Care Coordination and are acceptable if they are clearly identified in the progress note as Care Coordination/Home Telehealth and electronically captured. |
| 4 | | ccbps  ccbpd | Enter the most recent blood pressure documented in the record by Care Coordination (CC/H). | \_\_ \_\_ \_\_  /\_\_ \_\_ \_\_  **Abstractor can enter zzz/zzz**  **If valid, go to ccbpdt**  **If z-filled, auto-fill ccbpdt as 99/99/9999 and go to scibp as applicable**  Will be auto-filled as zzz/zzz if encarcor = 2   |  | | --- | | Warning if ccbps <= 80 or > = 250  Warning if ccbpd < = 44 or > = 135  Hard edit: ccbps and ccbpd must be > 0  Hard edit: ccbps must be > than ccbpd | | **Care Coordination (CC/H) electronic capture of BP:** patient measures his BP and the readings are electronically transmitted to Care Coordination. This BP reading cannot be changed by the patient and does not involve patient interpretation.  The BP readings are entered into the legal medical record by Care Coordination and are acceptable if they are clearly identified in the progress note as Care Coordination/Home Telehealth and electronically captured.  If BP was not recorded by Care Coordination within the past year, enter default zzz/zzz.  **Unacceptable:**  BP taken by patient or caregiver at home and result phoned to VHA provider. |
| 5 | | ccbpdt | Enter the date this blood pressure was measured. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if encarcor or ccbps is z-filled   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| **If catnum = 61, go to scibps; else go weight** | | | | | |
| 6 | | scibps  scibpd | Enter the patient’s last blood pressure measured prior to discharge during the patient’s most recent inpatient admission. | \_\_ \_\_ \_\_  /\_\_ \_\_ \_\_  Abstractor can enter zzz/zzz  If z-filled, auto-fill scibpdt as 99/99/9999 and go to weight   |  | | --- | | Warning if scibps <= 80 or > = 250  Warning if scibpd < = 44 or > = 135  Hard edit: scibps and scibpd must be > 0  Hard edit: scibps must be > than scibpd | | Enter the last BP recorded on the day of discharge OR if a BP was not recorded on the day of discharge, enter the last BP recorded prior to the day of discharge.  If a blood pressure was not documented during the most recent inpatient admission, enter default zzz/zzz. |
| 7 | | scibpdt | Enter the date this blood pressure was measured. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if scibp  z-filled   |  | | --- | | >= admdt and <=dcdate | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.  If SCIBPS and SCIBPD were z-filled, the date will be auto-filled as 99/99/9999. The abstractor cannot enter the 99/99/9999 default date if valid BP numbers were entered in SCIBPS and SCIBPD. |
|  | |  | **Weight** |  |  |
| 8 | | weight | Enter the patient’s weight measured most recently within the past year. | \_\_\_\_\_  **Abstractor can enter default zzz if weight not measured within past year**  If z-filled, auto-fill wtunit as 95 and go to height | **Source:** May be taken from either the inpatient or outpatient record  **Rules:** Use the most recent weight recorded in the medical record within the study parameters. If more than one weight is recorded during the most recent encounter, and the weights differ, use the lowest weight.  **Enter default zzz if patient’s weight was not measured within the past year.** |
| 9 | | wtunit | Unit of measure:   1. Pounds 2. Kilograms    1. Not applicable | 1,2,95  If weight z-filled, will be auto-filled as 95   |  | | --- | | Warning window: when wtunit = 1 and weight < = 98 or > = 278  When wtunit = 2, and weight < = 44 or > = 126 | | BMI is calculated in kilograms. If pounds are entered, the computer will convert pounds to kilograms in making the calculation. The resulting BMI is displayed on the computer screen.  Abstractor cannot enter 95 if valid weight was entered in WEIGHT. |
| 10 | | height | Enter the patient’s height. | \_\_\_\_\_ **Abstractor can enter default zzz if no height available**  If z-filled, auto-fill htunit as 95 and go to entrbmi | **No time period applies to this element.** If more than one height is recorded, use the most recent.  Height must be entered wholly in inches or centimeters. If pt. is 5 feet 8 inches, enter 68. 5ft = 60 in. 6ft = 72in. **Enter default zzz if no height can be found in the record.** |
| 11 | | htunit | Unit of measure:   1. Inches 2. Centimeters    1. Not applicable | 1,2,95  If height z-filled, will be auto-filled as 95  If weight z-filled, go to entrbmi   |  | | --- | | Warning window: when htunit = 1, and height < = 56 or > = 77  when htunit = 2, and height < = 156 or > = 191 | | Body Mass Index = Wt (kg)/ Ht\*Ht (M). If BMI is 25 –29.9, the patient is defined as overweight. If BMI is 30 or >, the patient is defined as obese.  BMI will be displayed on computer screen once the height unit is entered, if the weight, weight unit, and height have also been entered.  HTUNIT will be auto-filled as 95 if no valid height was entered. Abstractor cannot enter 95 if valid value was entered in question HEIGHT. |
|  | |  | **MOVE! Weight Management Program** |  |  |
| 12 | | entrbmi | Enter the patient’s most recent BMI documented in the record within the past year. | \_\_ \_\_.\_\_  **Abstractor can enter zz.z if no BMI documented in record**  **Only display entrbmi in software if BMI could not be calculated** | Enter the most recent BMI documented in the record with the past year by facility personnel.  BMI may sometimes be found documented with other vital signs within progress notes.  **If no BMI is documented in the record within the past year, enter zz.z.** |
| 13 | | nowttx  nowttx1  nowttx2  nowttx3  nowttx4  nowttx5  nowttx99 | Within the past year, does the record document any of the following indicators that weight management treatment was not appropriate?  **Indicate all that apply:**   1. Documented life expectancy of < 6 months 2. Patient enrolled in Hospice Care 3. Hospitalization for any reason in the 3 months prior to the most recent weight measurement 4. Physician/APN/PA documentation that patient was not a suitable candidate for weight management due to competing co-morbidities, frequent hospitalizations, and/or other health status reasons 5. Pregnancy or postpartum period 6. None of the above documented | 1,2,3,4,5,99  **Question nowttx is applicable to ALL patients**   |  | | --- | | Can only select 5 if sex = female |   **\*If nowttx = 1,2,3,4, or 5, auto-fill permnotx as 95, waistcir as 95, obesdx as 95, movetx as 95, movedate as 99/99/9999, and go to asesadl** | The intent of this question is to exclude patients with certain health conditions from the MOVE indicators. Patients with limited life expectancy or other health conditions that would limit the benefit of any weight management treatment or would severely limit the patient’s ability to participate in weight management treatment are excluded from the MOVE indicators.   * Patient’s life expectancy of less than six months must be documented by a physician, APN, or PA in the problem list, in the computer field “health factors,” or in the progress notes. * Notation of patient enrollment in Hospice is sufficient to enter “2.” * Notation of patient’s pregnancy or delivery of baby during the past year by a nurse or clinician is sufficient to select value 5.   Examples of health conditions that may limit patient’s ability to participate in weight management treatment include (but are not limited to): acutely exacerbated substance abuse or mental health conditions, acutely exacerbated chronic medical conditions (e.g., congestive heart failure, COPD, musculoskeletal illness/injury, acute moderate-serious infections or injuries).  **Examples of physician/APN/PA documentation that patient was not a suitable candidate for weight management:**  “Patient with BMI 32 but weight management treatment not appropriate at this time due to acute exacerbation of COPD.”  “Patient is obese based on BMI, but is experiencing mental status changes which make weight management treatment difficult at this time. Will defer discussion for when patient’s mental status has improved.”  **Note:** Clinician documentation that weight management treatment is not appropriate because the patient has a normal BMI or a BMI 25- 29.9 without obesity associated conditions does not meet the intent of this question. Enter “99.” |
| 14 | | permnotx | During the year prior to the past year, is there physician/APN/PA documentation of a permanent contraindication to weight management treatment?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nowttx = 1,2,3,4, or 5  **If 1, auto-fill waistcir as 95, obesdx as 95, movetx as 95, movedate as 99/99/9999, and go to asesadl; else if 2, go to waistcir** | **Year prior to the past year** = Determine “the past year” by counting back one year to the first day of the month of the first date of the study interval (as is calculated for “within the past year.”). Look for a permanent contraindication to weight management treatment documented during the year prior to this date. (Example: The study begin date is 11/01/12; one year previous to past year would be 11/01/10 to 10/31/11).  **Look in the computer field “health factors” for documentation of a permanent contraindication to weight management treatment. The health factor must be verified by physician/APN/PA documentation in the medical record. Each health factor should have an associated date that represents the date the health factor was recorded.**  Examples of permanent contraindications to weight management may include (but are not limited to): terminal or end stage disease (e.g., ESRD, end-stage COPD), progressive neurologic condition (e.g., ALS, Dementia, Parkinson’s disease) |
| 15 | | waistcir | During the past year, is the patient’s waist circumference above 40 inches (102cm) if male or above 35 inches (88 cm) if female?   1. Yes (WC is above threshold) 2. No (WC is at or below threshold)   95. Not applicable  99. No waist circumference documented | 1,2,95, 99  Will be auto-filled as 95 if nowttx = 1,2,3,4, or 5, or if permnotx = 1 | Waist circumference may be referred to as abdominal girth (AG) and is sometimes recorded with other vital signs or noted in provider progress notes.  A high waist circumference is associated with an increased risk for type 2 diabetes, dyslipidemia, hypertension, and CVD. |
| 16 | | obesdx  obesdx1  obesdx2  obesdx3  obesdx4  obesdx5  obesdx7 | Within the past year, does the record document a diagnosis of any of the following obesity-related comorbidities?   1. Diabetes 2. Obstructive sleep apnea 3. Hypertension 4. Hyperlipidemia/dyslipidemia 5. Degenerative Joint Disease   7. Metabolic syndrome  1. Yes  2. No   1. Not applicable | 1,2,95  Will be auto-filled as 95 if nowttx = 1,2,3,4, or 5, or if permnotx = 1  **If dmflag = 1, auto-fill obesdx1 as 1**  **If selhtn = -1, auto-fill obesdx3 as 1**   |  | | --- | | **If obesdx3 = 1, auto-fill selhtn as 1** |   **If (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99), auto-fill movetx as 95, movedate as 99/99/9999, and go to asesadl as applicable, else go to movetx** | **Review the medical record documentation for EACH of the medical diagnoses for this question.**  Documentation of medical diagnoses:   * Medical diagnoses **must be documented** in the clinic notes, problem list, or health factors by a physician, APN, or PA * Diagnoses documented in a clinical reminder by a RN, LPN, or KT (kinesiotherapist) must be confirmed in the medical record by clinician documentation. * **Diabetes** will be auto-filled if DM flag is present. * **Obstructive sleep apnea**: look in progress notes and problem list for this diagnosis. ICD-10 codes G4730 and R0681 may be indicative of obstructive sleep apnea. * **Hypertension** will be auto-filled if selected in the Validation Module. * **Do not select hyperlipidemia/dyslipidemia based on lipid profile results. There must be a specific diagnosis of hyperlipidemia or dyslipidemia documented by a designated clinician.** * **Degenerative joint disease may be selected if a diagnosis of osteoarthritis is documented by a designated clinician.** Look for ICD-10 codes M150-M153, M158, M159, M167, M169, M175, M179, M189, M1610, M1710, M1990, M1991, M1993, M19019, M19029, M19039, M19049, M19079, M19279. * Do not select metabolic syndrome based on an elevated fasting glucose and/or elevated triglycerides. There must be a specific diagnosis of metabolic syndrome documented by a designated clinician. Look in problem list or clinic notes. ICD-10 code E8881 may be indicative of metabolic syndrome.   **Source:** Diagnoses may be taken from either the inpatient or outpatient record. |
| 17 | movetx | | Within the past year, did the patient participate in weight management treatment on at least one occasion?   1. Patient participated in VA weight management treatment 2. Patient participated in non-VA weight management treatment 3. Patient did not participate in any weight management treatment 4. Not applicable | 1,2,3,95  Will be auto-filled as 95 if nowttx = 1,2,3,4, or 5, OR if permnotx = 1, OR  if (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99)  If movetx = 3, auto-fill movedate as 99/99/9999, and go to asesadl as applicable | Look in progress notes for documentation that the patient participated in weight management treatment on at least one occasion. Acceptable documentation could include:   * Clinic notes specifying the provision of weight management counseling or treatment in group or individual formats. Methods of delivery could include face-to-face visits, phone calls, home telehealth, or clinical video telehealth encounters. * Evidence that the clinician discussed the patient’s completed multifactorial assessment results (e.g., MOVE!11 questionnaire, or associated patient and/or healthcare provider reports) with the patient.   For the purpose of this question, clinician includes licensed health care provider (e.g., physician/APN/PA, RN, LPN, psychologist, registered dietician, rehabilitation therapist, social worker) or health care provider who is under supervision of the licensed health care provider.   * Evidence that the patient is participating in MOVE! Telephone Lifestyle Coaching (MOVE! TLC). * Evidence that the patient is participating in a home telehealth version of MOVE! (sometimes called TeleMOVE!) that may be delivered through an in-home messaging device or interactive voice response. * Evidence that the patient is using the MOVE! Coach mobile application in conjunction with clinical support provided in-person, by phone, or via secure messaging (MOVE! Coach with Care). * Notation from the clinician that patient is participating in a non-VA, clinically-supported (i.e., includes group or individual contact with a coach or clinical staff) weight management program that targets more than one aspect of weight management (e.g., Weight Watchers, TOPS Club, HMR program, Optifast, Curves Complete, etc.). Clinically-supported web-based or mobile application weight loss programs are acceptable. * For the purposes of this measure, weight management treatment programs that target only one aspect of weight management (e.g. Nutrisytem, Curves Fitness, etc.) are not acceptable.   If the patient did not participate in weight management treatment or there is documentation the patient refused weight management within the past year, enter “3.” |
| 18 | movedate | | Enter the date of the most recent weight management treatment visit or telephone contact. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if nowttx = 1,2,3,4, or 5, OR if permnotx = 1, OR if (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99), or if movetx = 3   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Look in the progress notes for documentation of the date of the most recent visit or phone contact related to MOVE!23, MOVE!11, or other VA weight management treatment.  If patient is receiving weight management treatment outside of the VA, look for documentation/confirmation by a VA clinician of the patient’s continued participation in the non-VA program. Enter the date of the most recent note that confirms/documents continued participation in a non-VA program.  Enter the exact date. The use of 01 to indicate missing month or year is not acceptable. |
| **If patient age 75 or >, go to asesadl; else go out of Module** | | | | | |

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|  |  | **Frail Elderly** |  |  |
| 19 | asesadl | Within the past 12 months, was an assessment of the patient’s ADLs performed using a standardized and published tool?  1. Yes  2. No | 1,2  If 2, auto-fill adldt as 99/99/9999, and go to asesiadl | Activities of daily living include bathing, dressing, toileting, transferring, continence, and feeding.  **Standardized and published Tools: Katz Index of Independence in Activities of Daily Living**  Katz Index of Independence in Activities of Daily Living assesses the patient’s independence or dependence in six areas: bathing, dressing, toileting, transferring, continence, and feeding.  The total points range from 0 (patient very dependent) to 6 (patient independent).  Other tools are acceptable but must be standardized and published.  If another standardized and published tool is used, the tool must be named, and the questions and scoring must be in accordance with the authentic screening tool.  In order to answer “1,” the documentation must clearly indicate that ADLs were assessed using a standardized and published tool and interpretation of the results must be documented. |
| 20 | adldt | Enter the date of the most recent assessment of ADLs using a standardized and published tool. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  asesadl = 2   |  | | --- | | < = 12 mos prior to or = stdybeg and < = stdyend | | Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable. |
| 21 | asesiadl | Within the past 12 months, was an assessment of the patient’s instrumental activities of daily living (IADLs) performed using a standardized and published tool?  1. Yes  2. No | 1,2  If 2, auto-fill iadldt as 99/99/9999 and go to askfalls | **Instrumental activities of daily living includes ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.**  **IADL standardized and published tool: Instrumental Activities of Daily Living Scale (IADL) M.P. Lawton and E.M. Brody**  **Lawton Instrumental Activities of Daily Living Scale assesses eight domains of independent living skills: ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.**  **A summary score ranges from 0 (low function, dependent) to 8 (high function, independent).**  Other tools are acceptable but must be standardized and published.  In order to answer “1,” the documentation must clearly indicate that IADLs were assessed using a standardized and published tool and the interpretation of the results must be documented. |
| 22 | iadldt | Enter the date of the most recent assessment of IADLs using a standardized and published tool. | mm/dd/yyyy   |  | | --- | | < = 12 mos prior to or = stdybeg and < = stdyend |   Will be auto-filled as 99/99/9999 if  asesiadl = 2 | Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable. |
|  |  | **Falls** |  |  |
| 23 | askfalls | During the past twelve months, was the patient asked about the presence/absence of any falls during the preceding 12 months?  1. Yes  2. No | 1,2  If 2, go to uicode | For persons age 75 or older, a falls history should be obtained on annual basis. **In order to answer “1,” documentation within the past 12 months must indicate the patient was asked about the presence/absence of any falls during the preceding 12 months. Sources: Inpatient or outpatient record**. Inpatient Nursing Assessment is suggested as a likely source. |
| 24 | askfaldt | Enter the date the patient was most recently questioned about falls during the preceding 12 months. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if askfalls = 2   |  | | --- | | < = 12 mos prior to or = stdybeg and < = stdyend | | Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable. |
|  |  | **Urinary Incontinence** |  |  |
| 25 | uicode | Within the past 12 months, did the patient record contain a urinary incontinence  ICD-10-CM code R32, N3941, N393, N3946, N3942, N3943, N3944, N3945, N39490, N39498, or F980  1. Yes  2. No | \*1,2  \*If 1, go to end | ICD-10 R32, N3941, N393, N3946, N3942, N3943, N3944, N3945, N39490, N39498: Incontinence of urine codes  ICD-10 F980: enuresis of non-organic origin. Involuntary urination past age of normal control; also called bedwetting, no trace to biological problem; focus on psychological issues  ICD-10 N3644: detrusor sphincter dyssynergia  ICD-10 N3642: intrinsic (urethral) sphincter deficiency  ICD-10 N393: stress incontinence, female. Involuntary leakage of urine due to insufficient sphincter control; occurs upon sneezing, laughing, coughing, sudden movement, or lifting  ICD-10 R3981: Urinary incontinence, functional/urinary incontinence associated with cognitive impairment |
| 26 | uiscrapp | Did the record document that screening for the presence of urinary incontinence is appropriate for this patient?   1. Yes 2. No, patient already known to have urinary incontinence 3. No, patient has a urinary ostomy appliance, supra-pubic catheter, or Foley catheter in place | 1,2,3  If 2 or 3, go to end | **Appropriate for UI screening** = Patients without known problem of urinary incontinence  If there is documentation of pre-existing urinary incontinence, enuresis, intrinsic (urethral) sphincter deficiency, or detrusor sphincter dyssynergia, select “2.”  If there is documentation the patient has a urinary ostomy appliance, supra-pubic catheter, or Foley catheter in place, answer “3.” |
| 27 | uiscreen | Within the past 12 months, was the patient screened for urinary incontinence?  1. Yes  2. No | 1, 2  If 2, go to end | **Acceptable as screening for urinary incontinence (UI):**   * UI observed (urine odor or stained garments, direct observation of urine loss during examination) * UI reported spontaneously * UI reported in response to specific questioning. There must be mention of questioning on “leakage”, “urine loss”, “incontinence”, or “urinary incontinence.” A generic review of systems listed as “negative for renal disease” or “no bowel or bladder problems” without mention of questioning for UI would not be acceptable. Documentation of “genitourinary system review of symptoms negative” is acceptable. |
| 28 | uiscrndt | Enter the most recent date the patient was screened for urinary incontinence. | mm/dd/yyyy   |  | | --- | | < = 12 mos prior to or = stdybeg and < = stdyend | | Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable. |