|  |
| --- |
| **[Link to Mnemonics and Questions](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2019q3/MnemonicQuestions3q19.xlsx)** |
| 1 | lossense | Does the patient have any of the following physical/neurological impairments?2. quadriplegia/paraplegia3. past stroke, resulting in bilateral sensory loss in feet99. none of these impairments | 2,3,99 | Quadriplegia = paralysis of all four limbsParaplegia = paralysis of the lower part of the body including the legsResponse #3 may not be used if the sensory loss is confined to one foot. |
| 2 | amputee | Does the patient have a lower extremity amputation?1. Unilateral amputation2. Bilateral amputation99. No documentation of lower extremity amputation | 1,2,99**If 2, auto-fill footinsp, footplse, and footsens as 95, and go to kidisdx** | Lower extremity amputation = removal of one (unilateral) or both (bilateral) lower extremities. Amputation of a lower extremity amputation may be above or below the knee. |
| 3 | footinsp | Within the past year, does the record document a visual inspection of the patient’s feet?1. Yes2. No95. Not applicable98. Patient refused foot exam | 1,2,95,98If amputee = 2, will be auto-filled as 95 | If a checklist is used to denote visual foot inspection, a notation of findings, e.g., WNL, must be present in addition to date and initials or signature of individual performing the exam. Patient must have had a clinic visit on that date.If patient is unilateral amputee of lower extremity, question is pertinent to the remaining foot.1. Referral to a podiatrist, without documented notes, is acceptable only for the visual foot exam and only if the record verifies the patient kept the appointment.2. The following are not acceptable unless the foot is specifically mentioned: “extremities negative, lower extremity exam, 1+ edema, extremities – no edema.” Patient self-report is also not acceptable.3. Acceptable: diabetic foot care (DFC), cyanosis of the toes/feet, edema of the feet, skin exam of foot, toe check/exam, toenail clipping, onychomycosis of toenails, ulcers, pedal edema, feet WNL.In order to answer “98,” there must be documentation in the record by the provider that the patient refused to have a foot inspection.  |
| 4 | footplse | Within the past year, does the record document pulses were checked in patient’s feet?1. Yes2. No95. Not applicable98. Patient refused foot exam | 1,2,95, 98If amputee = 2, will be auto-filled as 95 | 1. Foot should be examined to determine presence of dorsalis pedis (DP) and posterior tibial pulses. (One is sufficient.) There must be documentation in the record indicating that pulses were or were not palpable. Body outline with 1+, etc. marked at pulse points is acceptable if feet are included.2. If services provided by the podiatrist were limited to nail-cutting, answer ‘1’ to footinsp, but ‘2’ to footplse, unless the record specifically states pulses were palpated.In order to answer “98,” there must be documentation in the record by the provider that the patient refused to have assessment of pulses in feet. |
| 5 | footsens | Within the past year, does the record document the result of testing for foot sensation by monofilament?1. Yes2. No95. Not applicable98. Patient refused monofilament testing | 1,2,95,98**If lossense = 2 or 3, or amputee = 2, auto-fill as 95** | **The use of monofilament to test sensation and the result of the testing must be documented in the medical record. A general statement that “monofilament is always used” is not acceptable.****If the facility is using the “Vibration Perception Threshold Test,” accept as equivalent to monofilament and answer “yes.”** If services provided by a podiatrist were limited to nail-cutting, answer ‘1’ to footinsp, but ‘2’ to footsens, unless record specifically states sensation was tested by monofilament.In order to answer “98,” there must be documentation in the record by the provider that the patient refused to have testing for foot sensation by monofilament.  |
| 6 | kidisdx | Within the past year, did the patient have an active diagnosis of diabetic nephropathy or documented end-stage renal disease (ESRD)?1. Yes2. No | 1,2Computer will auto-fill as 1 if selckd = -1

|  |
| --- |
| Warning if 2 and selckd = -1 |

 | **Review the medical record documentation to determine if there is an active diagnosis of diabetic nephropathy as indicated by any of the following:*** acute renal failure (ARF)
* arterionephrosclerosis
* azotemia
* chronic kidney disease (CKD)
* chronic renal disorder
* chronic renal failure (CRF)
* chronic renal insufficiency
* diabetic kidney disease
* dialysis (hemodialysis or peritoneal dialysis)
* diffuse diabetic or nodular glomerulosclerosis
* Kimmelstein-Wilson lesion
* papillary necrosis
* renal insufficiency
 |
| 7 | rnltrans | Is there documentation the patient had renal (kidney) transplantation?1. Yes2. No | 1,2 | Kidney transplantation is a procedure that places a healthy kidney from a donor into the body of a patient who has end stage renal disease.  |
| 8 | seeneph | Within the past year, was the patient seen at any time by a nephrologist?1. Yes2. No | 1,2 | Seen by nephrologist: may be clinic visit or during an inpatient episode of care. To answer “1,” the specialist seeing the patient must be clearly identified as a nephrologist.  |
| 9 | fundexam | Within the past year, does the record document a funduscopic examination of the retina?1. exam performed by VHA
2. exam performed by a private sector provider
3. explicit statement by ophthalmologist or optometrist that retinal imaging no longer necessary for this blind patient
4. Patient refused funduscopic examination of retina

99. no documentation funduscopic exam was  performed | 1,3,97,98,99**If 97, 98, or 99, auto-fill fundt as 99/99/9999, eyespec as 95, and go to prevscop** | Blind patients are not excluded from this question unless option #97 is applicable.Documentation that indicates funduscopic exam of the retina was performed: reference to optic disc, arterioles, no hemorrhage or exudates, microaneuryms, no papilledema, any reference to terms indicating retinopathy. Documentation of a dilated eye exam may include abbreviations such as Dil, DL, DI, or DFE. The term “non-mydriatic” means non-dilated.**Documentation Acceptable to Select Value “1” or “3”:*** Presence of a note, report, or letter summarizing results of a retinal or dilated eye exam completed by an eye care specialist (ophthalmologist or optometrist), or a photograph or chart of retinal abnormalities
* Note by the PCP/staff that the funduscopic or retinal examwas completed by a private eye care specialist (ophthalmologist or optometrist), date of exam, and result of exam. The month and year should be known.
* Retinal photo taken in the ambulatory care setting and sent to an eye care specialist for review, **if the results are in the record.**
* Screening for retinopathy by digital imaging (dilated or non-dilated), read by an ophthalmologist or optometrist
* Documentation of bilateral eye enucleation (removal of both eyes) anytime during the Veteran’s history.

**Unacceptable:**Pt referred to ophthalmology/optometry but no exam results available. In order to answer “98,” there must be documentation in the record by the provider that the patient refused to have a funduscopic exam of the retina performed. |
| 10 | fundt | Enter the date the funduscopic exam of the retina was performed. | mm/dd/yyyyIf fundexam = 97, 98 or 99, will be auto-filled as 99/99/9999

|  |
| --- |
| < = 1 year prior or = stdybeg and < = stdyend |

 | Day may be entered as 01, if exact date is unknown. At a minimum, the month and year must be entered accurately.If FUNDEXAM = 97 or 99, FUNDT will auto-fill as 99/99/9999. Abstractor cannot enter the default date of 99/99/9999 if FUNDEXAM = 1 or 3. |
| 11 | eyespec | How was the funduscopic/retinal exam performed?1. by an ophthalmologist
2. by an optometrist
3. by a primary care practitioner

6. a digital image/retinal photo (dilated or non-dilated)was sent to be read by an ophthalmologist or optometrist 1. not applicable

99. unable to determine from documentation in the medical record | 1 2,3,6,95,99If fundexam = 97, 98, or 99, will be auto-filled as 95**If 3 or 99, go to prevscop; else go to end** | **Eye care specialist=ophthalmologist or optometrist****Scoring for the retinal or dilated retinal exam of diabetic patients will be based on whether the exam was performed by an ophthalmologist or optometrist, by retinal photo sent to an eye care specialist or by funduscopic digital imaging (dilated or non-dilated) sent to an ophthalmologist or optometrist for reading.** If uncertain regarding the specialty of the clinicians who perform funduscopic exams at the VAMC, request assistance from the Liaison.**If the patient was seen by an eye care specialist outside VHA and it is known the eye exam was accomplished (i.e. documentation the funduscopic or retinal exam was done by eye care specialist, date of exam, and result of exam), but the specialty is unknown, use response “1” as default.** Answer ‘6’ as applicable to use of retinal digital imaging/retinal photo, either dilated or non-dilated, taken in Primary Care or other ambulatory clinic, and sent to an ophthalmologist or optometrist for reading.**If use of the Inoveon, Joslin, or Vanderbilt system is documented in the record, this is acceptable.**  |
| 12 | prevscop | Within the year previous to the past year, did the patient have a funduscopic exam of the retina performed by an ophthalmologist, an optometrist, or by retinal digital imaging sent to an ophthalmologist or optometrist for reading1. Yes
2. No
3. Explicit statement by ophthalmologist or optometrist that retinal imaging no longer necessary for this blind patient
 | 1,2,97**If 2 or 97, auto-fill prevdt as 99/99/9999, retinpath2 as 95, and go to end**  | **Year previous 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.”). The year’s period prior to this date is within the year previous to the past year.Blind patients are not excluded from this question unless option #97 is applicable.Documentation that indicates funduscopic exam of the retina was performed: reference to optic disc, arterioles, no hemorrhage or exudates, microaneuryms, no papilledema, any reference to terms indicating retinopathy. Documentation of a dilated eye exam may include abbreviations such as Dil, DL, DI, or DFE. The term “non-mydriatic” means non-dilated.**Acceptable:*** Presence of a note, report, or letter summarizing results of a retinal or dilated eye exam completed by an eye care specialist (ophthalmologist or optometrist), or a photograph or chart of retinal abnormalities
* Note by the PCP/staff that the funduscopic or retinal examwas completed by a private eye care specialist (ophthalmologist or optometrist), date of exam, and result of exam. The month and year should be known.
* Retinal photo taken in the ambulatory care setting and sent to an eye care specialist (ophthalmologist or optometrist) for review, **if the results are in the record.**
* **Screening for retinopathy by digital imaging (dilated or non-dilated), read by an ophthalmologist or optometrist**

**Unacceptable:**Pt referred to ophthalmology/optometry but no exam results available.  |
| 13 | prevdt | Enter the date of the retinal exam performed within the year previous to the past year. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if prevscop = 2 or 97If prevscop = 2 or 97, will be auto-filled as 99/99/9999

|  |
| --- |
| < = 2 yrs prior to stdybeg and > 1 yr prior to stdybeg |

 | Day may be entered as 01, if exact date is unknown. At a minimum, the month and year must be entered accurately.Will auto-fill as 99/99/9999 if PREVSCOP = 2 or 97. Abstractor cannot enter the default date of 99/99/9999 if PREVSCOP = 1.  |
| 14 | retinpath2 | Did the report from the retinal eye exam within the year previous to the past year indicate a finding of retinopathy?1. Yes2. No95. Not applicable99. No report available | 1,2,95,99Will be auto-filled as 95 if prevscop = 2 or 97 | **The intent of the eye exam indicator is to ensure that patients with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.** * + - * **If there is documentation of a negative retinal or dilated eye exam by an eye care professional (optometrist, ophthalmologist), select “2”.**
* **Documentation does not have to state specifically “no diabetic retinopathy” to be considered negative for retinopathy; however it must be clear that the patient had a dilated or retinal eye exam and retinopathy was not present.**
	+ - * **If there is any documentation of retinopathy (including hypertensive) or retinopathy synonym, select “1.”**

**Proliferative Diabetic Retinopathy Synonyms:**Any hemorrhage PhotocoagulationPreretinal or vitreous hemorrhage Rubeosis Background retinopathy IritisDiabetic retinal or eye changes FibrosisLaser treatment of the eyes Diabetic iritisMacular lesionNew vessels on the disc, (NVD) iris, or retinaMacular changes with retinopathyPreproliferative Retinopathy Synonyms:Diabetic macular edema Multiple cotton wool spotsRetinal blot hemorrhages Venous beading/loopingIntraretinal microvascular abnormalities (IRMA)Nonproliferative Diabetic Retinopathy Synonyms:Blot hemorrhage Microaneuryms Hard exudates Soft exudates**Exclude:** macular degeneration w/o mention of retinopathyR/O retinopathy; rule out retinopathy |