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| [**Link to Mnemonics and Questions**](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2025q2/MnemonicQuestions2025q2.xlsx) | | | | |
| 1 | lossense | Does the patient have any of the following physical/neurological impairments?  2. quadriplegia/paraplegia  3. past stroke, resulting in bilateral sensory loss in feet  99. none of these impairments | 2,3,99 | Quadriplegia = paralysis of all four limbs  Paraplegia = paralysis of the lower part of the body including the legs  Response #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 amputation  2. Bilateral amputation  99. No documentation of lower extremity amputation | 1,2,99  **If 2, auto-fill footinsp2, ftsenart, footplse, and footsens as 95, auto-fill footinsdt as 99/99/9999, and go to renaldis** | 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 | footinsp2 | Within the past year, does the record document a visual inspection of the patient’s feet during a face-to-face (in person) or clinical video telehealth (CVT, VA Video Connect (VVC)) visit?  3. Yes, visual inspection of the patient’s feet was documented during a face-to-face visit  4. Yes, visual inspection of the patient’s feet was documented during a CVT or VVC visit  5. No documentation of a visual inspection of the patient’s feet during the past year  95. Not applicable  98. Patient refused foot exam | 3,4,5,95,98  If amputee = 2, will be auto-filled as 95  If 5 or 98, go to footplse | * Visual inspection of the patient’s feet may be performed by any healthcare provider including but not limited to: physician/APN/PA, registered nurse, licensed practical nurse, health technician. * Patient self-report is not acceptable. * If a checklist is used to denote visual foot inspection, a notation of findings (e.g., within normal limits (WNL)) must be present in addition to date and initials or signature of individual performing the exam. Patient must have had a face-to-face, clinical video telehealth (CVT) or VVC visit on that date. * If the visual inspection of the patient’s feet was documented during a face-to-face visit, select value 3. Note: If a patient is onsite at a VA clinic for a CVT visit (telehealth connection to a provider at another facility) and a provider at the onsite clinic performs and documents a visual inspection of the patient’s feet, select value 3. * If the visual inspection of the patient’s feet was documented during a CVT or VVC visit, select value 4. * If patient has a unilateral amputee of lower extremity, question is pertinent to the remaining foot. * 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. * **Examples of acceptable documentation include but are not limited to:** cyanosis of the toes/feet, diabetic foot care (DFC), edema of the feet, feet WNL, no significant abnormalities, onychomycosis of toenails, pedal edema, skin exam of foot, toe check/exam, toenail clipping, ulcers. * **The following are not acceptable unless the feet are specifically mentioned:** extremities negative, lower extremity exam, 1+ edema, extremities – no edema * 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 | footinsdt | Enter the date of the most recent visit with documentation of a visual inspection of the patient’s feet. | mm/dd/yyyy  If footinsp2 = 3, go to footplse   |  | | --- | | <= 1 yr prior to stdybeg and <= stdyend | | Enter date of the most recent visit with documentation of a visual inspection of the patient’s feet. |
| 5 | ftsenart1  ftsenart2  ftsenart95  ftsenart99 | During the CVT or VVC visit on (computer display footinsdt), did the healthcare provider ask the patient about any of the following signs and symptoms in the patient’s feet?  **Select all that apply:**   1. Signs and symptoms of sensory loss 2. Signs and symptoms of reduced arterial circulation   95. Not applicable  99. None of the above documented | 1,2,95,99  If amputee = 2, will be auto-filled as 95  Cannot select 99 with any other value | Value 1 = Signs and symptoms of sensory loss in the feet may include but are not limited to: numbness, pain, prickling or tingling sensation, sensitivity to touch, weakness.  Value 2 = Signs and symptoms of reduced arterial circulation in the feet may include but are not limited to: coldness, numbness, pain, slower growth of toenails, sores that do not heal, weakness.  If numbness, pain, or weakness is documented, select values 1 and 2.  If there is no documentation the provider asked the patient about signs and symptoms of sensory loss or reduced arterial circulation in the feet, select value 99. |
| 6 | footplse | Within the past year, does the record document pulses were checked in patient’s feet?  1. Yes  2. No  95. Not applicable  98. Patient refused foot exam | 1,2,95, 98  If amputee = 2, will be auto-filled as 95 | * Checking pulses in the patient’s feet may be performed by any healthcare provider including but not limited to: physician/APN/PA, registered nurse, licensed practical nurse, health technician. * Each foot (unless unilateral amputee) should be examined to determine presence of dorsalis pedis (DP) and/or posterior tibial pulses. * There must be documentation in the record indicating that pulses (i.e., dorsalis pedis and/or posterior tibial) were or were not palpable. * Body outline with 1+, etc. marked at pulse points is acceptable if feet are included. * 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. |
| 7 | footsens | Within the past year, does the record document the result of testing for foot sensation by monofilament?  1. Yes  2. No  95. Not applicable  98. Patient refused monofilament testing | 1,2,95,98  **If lossense = 2 or 3, or amputee = 2, auto-fill as 95** | * Testing for foot sensation by monofilament may be performed by any healthcare provider including but not limited to: physician/APN/PA, registered nurse, licensed practical nurse, health technician. * **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.” * Documentation of Semmes-Weinstein monofilament (SWM) testing with 5.07 monofilament is acceptable. May also be documented as SW 5.07 or SWM 5.07. * 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. |
| 8 | renaldis | At any time prior to or on (computer to display stdyend) is there documentation in the medical record of any one of the following:   * End stage renal disease (ESRD) * Dialysis   1. Yes  2. No | 1,2  Computer will auto-fill as 1 if selckd = -1   |  | | --- | | Warning if 2 and selckd = -1 | | **Review the medical record documentation during the specified timeframe to determine if there is documentation of any of the following renal/kidney disorders:**   * **End stage renal disease (ESRD)** may include but is not limited to: * Chronic kidney disease, stage 5 (stage V) * End stage renal failure * **Dialysis** may include but is not limited to: * Hemodialysis * Peritoneal dialysis   **Refer to Table 9 for other specific terminology for ESRD and dialysis procedures.**  **Suggested Data Sources:** Progress notes, dialysis procedure notes, **Oracle Health Suggested Data Source**: Problem List (found in Patient Summary) |
| 9 | eyenucl | Is there documentation in the medical record that the patient has had any of the following:   * Left unilateral eye enucleation and a right unilateral eye enucleation on the same or different date * Bilateral eye enucleation * Two eye enucleations performed 14 days or more apart from each other  1. Yes 2. No | 1, 2  If 1, go to the end | **Enucleation is the removal of the eye from the orbit.**  **Acceptable documentation includes:**   * Bilateral eye enucleation (removal of both eyes) any time during the patient’s history through the study end date. * Two unilateral eye enucleations (removal of one eye and then removal of the other eye) with services dates 14 days or more apart (removal of one eye and then removal of the other eye). **For example:** If service date for the first unilateral eye enucleation was February 1 of the study year, the services date for the second unilateral eye enucleation must be on or after February 15 of the same year. |
| 10 | fundexam2 | 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, microaneurysms, 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 * Eye exam results read by a system that provides an artificial intelligence (AI) interpretation   Automated eye exam, Digital Retinal Imaging – where a machine is used to view the retina  **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. |
| 11 | fundt | Enter the date the funduscopic exam of the retina was performed. | mm/dd/yyyy  If fundexam2 = 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 FUNDEXAM2 = 97 or 99, FUNDT will auto-fill as 99/99/9999. Abstractor cannot enter the default date of 99/99/9999 if FUNDEXAM2 = 1 or 3. |
| 12 | eyespec | How was the funduscopic/retinal exam performed?   1. by an ophthalmologist 2. by an optometrist 3. by a primary care practitioner   6. automated 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 2,3,6,95,99  If fundexam2 = 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 or automated, 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.** |
| 13 | 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 automated retinal digital imaging sent to an ophthalmologist or optometrist for reading   1. 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 or automated, digital imaging of the retina was performed: reference to optic disc, arterioles, no hemorrhage or exudates, microaneurysms, 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 automated digital imaging (dilated or non-dilated), read by an ophthalmologist or optometrist**   **Unacceptable:**  Pt referred to ophthalmology/optometry but no exam results available. |
| 14 | prevdt | Enter the date of the retinal exam performed within the year previous to the past year. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if prevscop = 2 or 97  If 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. |
| 15 | retinpath2 | Did the report from the retinal eye exam within the year previous to the past year indicate a finding of retinopathy?  1. Yes  2. No  95. Not applicable  99. No report available | 1,2,95,99  Will 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 Photocoagulation  Preretinal or vitreous hemorrhage Rubeosis  Background retinopathy Iritis  Diabetic retinal or eye changes Fibrosis  Laser treatment of the eyes Diabetic iritis  Macular lesion  New vessels on the disc, (NVD) iris, or retina  Macular changes with retinopathy Preproliferative Retinopathy Synonyms: Diabetic macular edema Multiple cotton wool spots  Retinal blot hemorrhages Venous beading/looping  Intraretinal microvascular abnormalities (IRMA) Nonproliferative Diabetic Retinopathy Synonyms: Blot hemorrhage Microaneuryms  Hard exudates Soft exudates  **Exclude:** macular degeneration w/o mention of retinopathy  R/O retinopathy; rule out retinopathy |