

Quality ID #048: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

2025 COLLECTION TYPE:

MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.

INSTRUCTIONS:

This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure is appropriate for use in the ambulatory setting only and is considered a general screening measure. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: Patient encounters for this measure conducted via telehealth (including but not limited to encounters coded with GQ, GT, POS 02, POS 10) are allowable. Please note that effective January 1, 2025, while a measure may be denoted as telehealth eligible, specific denominator codes within the encounter may no longer be eligible due to changes outlined in the CY 2024 PFS Final Rule List of Medicare Telehealth Services.

Measure Submission Type:

Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

All female patients aged 65 years and older with a visit during the measurement period

Denominator Criteria (Eligible Cases):

All female patients aged ≥ 65 years on date of encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0402

AND NOT

DENOMINATOR EXCLUSION:

Patient use of hospice services any time during the measurement period: G9693

NUMERATOR:

Patients who were assessed for the presence or absence of urinary incontinence within 12 months

Definition:

Urinary Incontinence – Any involuntary leakage of urine.

Numerator Options:

Performance Met:

Presence or absence of urinary incontinence assessed
(1090F)

OR

Performance Not Met:

Presence or absence of urinary incontinence not assessed,
reason not otherwise specified **(1090F with 8P)**

RATIONALE:

Female patients may not volunteer information regarding incontinence, so they should be asked by their physician.

CLINICAL RECOMMENDATION STATEMENTS:

Strategies to increase recognition and reporting of urinary incontinence (UI) are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

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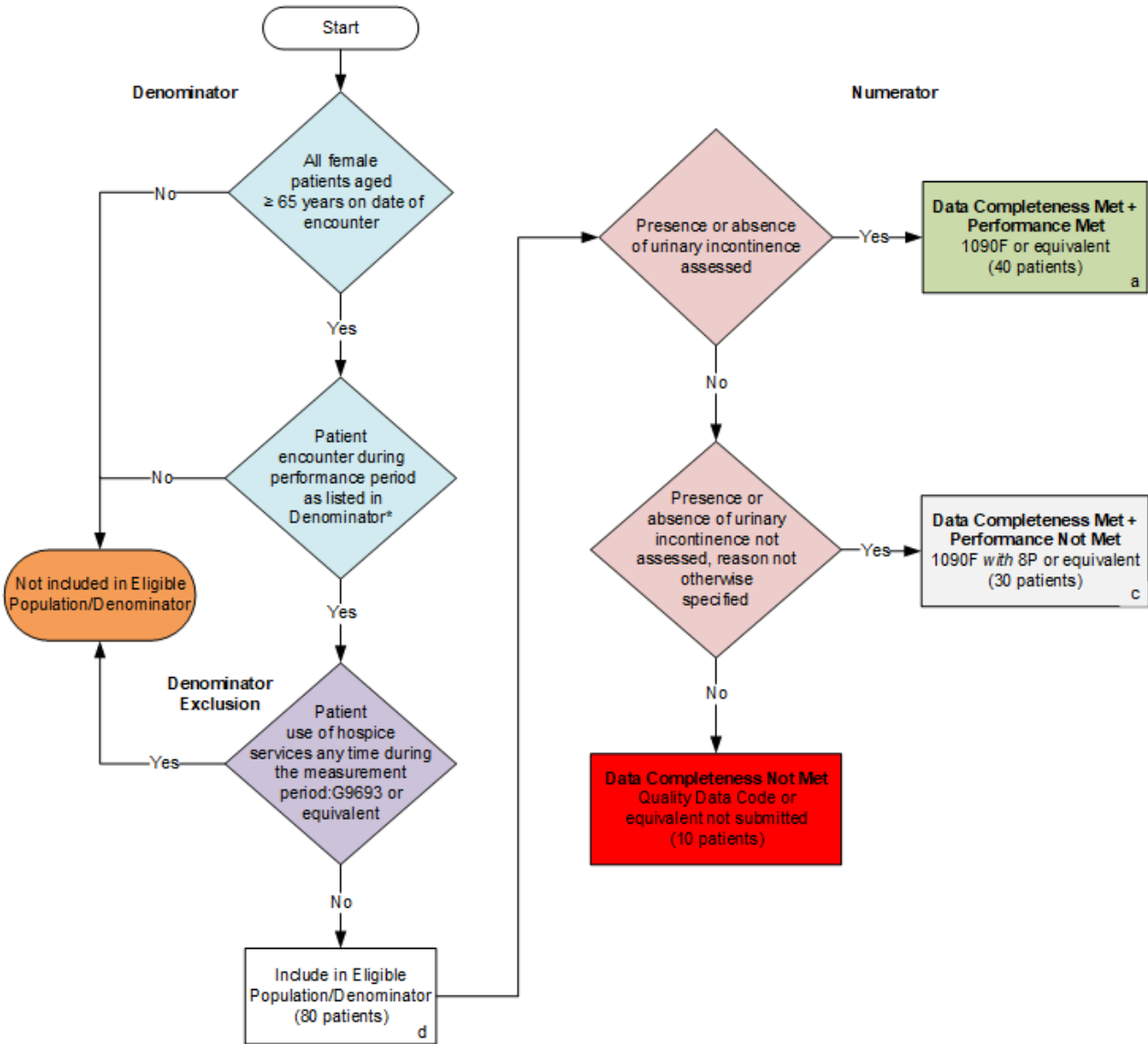
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2025 Clinical Quality Measure Flow for Quality ID #48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=40 patients)} + \text{Performance Not Met (c=30 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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 The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

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**2025 Clinical Quality Measure Flow Narrative for Quality ID #048:
Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women
Aged 65 Years and Older**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *All female patients aged greater than or equal to 65 years on date of encounter*.
 - a. If *All female patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *All female patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**.
 - a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to *Patient use of hospice services any time during the measurement period*.
4. Check *Patient use of hospice services any time during the measurement period*.
 - a. If *Patient use of hospice services any time during the measurement period* equals No, include in *Eligible Population/Denominator*.
 - b. If *Patient use of hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
5. Denominator Population:
 - a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Presence or absence of urinary incontinence assessed*.
 - a. If *Presence or absence of urinary incontinence assessed* equals Yes, include in *Data Completeness Met and Performance Met*.
 - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
 - b. If *Presence or absence of urinary incontinence assessed* equals No, proceed to *Presence or absence of urinary incontinence not assessed, reason not otherwise specified*.
8. Check *Presence or absence of urinary incontinence not assessed, reason not otherwise specified*.

- a. If *Presence or absence of urinary incontinence not assessed, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.
 - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
 - b. If *Presence or absence of urinary incontinence not assessed, reason not otherwise specified* equals No, proceed to *Data Completeness Not Met*.
9. Check *Data Completeness Not Met*:
- a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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