

♣ Measure #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

2010 PQRI REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented

Parameters: Age 65 and older BMI ≥ 30 or < 22

Age 18 – 64 BMI ≥ 25 or < 18.5

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The most recent quality code submitted will be used for performance calculation. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. For justification of BMI parameters for this measure please refer to the rationale and clinical recommendation statements. The documentation of a follow up plan should be based on the most recently calculated BMI.

Measure Reporting via Claims:

CPT codes, HCPCS (D- and G-) codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

Measure Reporting via Registry:

CPT codes, HCPCS (D- and G-) codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data.

NUMERATOR:

Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Definitions:

BMI – Body Mass Index (BMI) is a number calculated from a person’s weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems. BMI is calculated by dividing a person’s weight (in kilograms) by his/her height (in meters, squared). BMI can also be calculated by multiplying weight (in pounds) by 705, then dividing by height (in inches) twice. A simpler method to calculate the BMI involves the use of a chart. The weight is plotted on one axis and the height is plotted on the other axis. The BMI can then be read where the two points intersect. Example BMI charts are widely available via the internet.

Calculated BMI – Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.

Follow-up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral, prescription/administration of medications/dietary supplements, etc.

Terminal Illness – Life expectancy is 6 months or less

Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented

G8420: Calculated BMI within normal parameters and documented

OR

G8417: Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record

OR

G8418: Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI Outside of Normal Parameters, Follow-up Plan not Documented, Reason not Specified

G8421: BMI not calculated

OR

G8419: Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270

RATIONALE:

Of the Medicare population, 37 percent are overweight, and 18 percent are obese. Between 1991 and 1998, the prevalence of obesity among persons age 60-69 increased by 45 percent (American Obesity Association).

The economic impact of obesity and its related conditions in the U.S. economy is staggering and has been estimated at about \$117 billion according to the Midcourse Review of Healthy People 2010.

A recent study predicts that by 2020 there will be an 18 percent to 22 percent increase in the prevalence of Americans between the ages of 50 and 69 who have difficulty bathing, dressing or walking across a room if the current rate of weight increase for this age group continues. According to a 1998 survey, only 52 percent of adults age 50 or older reported being asked during routine medical check-ups about physical activity or exercise. The likelihood of being asked about exercise during a routine check-up declined with age (Center for the Advancement of Health, 2004).

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m² in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m². (Huffman, G. B., Evaluation and Treatment of Unintentional Weight Loss in the Elderly, American Family Physician, 2002 Feb, 4:640-650.)

A tremendous gap still exists between our knowledge of malnutrition and its sequelae and our actions in preventing and treating it. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes. Professionals of all disciplines need to help older individuals improve their oral health, mental health, medication use, food choices, economic situation, functional status and medical

condition and thereby improve both nutritional status and quality of life (American Dietetic Association, Nutrition Screening Initiative, 2002).

A Web search of the National Quality Measures Clearinghouse on the key words of BMI, body mass index, produced three measures, all focused on possible follow-up for overweight and obesity for a broader age range. There were no measures that focused on underweight or a follow-up plan.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. (Level of Evidence = B, USPSTF)

The clinical guideline for obesity recommends assessment of BMI at each encounter (National Heart, Lung and Blood Institute).

Validated measure of nutrition status serves as an indicator of over-nourishment and under-nourishment. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

The NSI-suggested BMI range is 22-27 (values outside this range indicate overweight or underweight for elderly) Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

Interventions can be grouped into six primary categories: Social Services, Oral Health, Mental Health, Medication Use, Nutritional Education and Counseling, and Nutritional Support. For further detail on any of the potential interventional strategies, see the Nutritional Interventions Manual for Professionals Caring for Older Americans, 2002. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).