♠Measure #128: Universal Weight Screening and Follow-Up

DESCRIPTION:
Percentage of patients aged 65 years and older with a calculated Body Mass Index (BMI) within the past six months or during the current visit that is documented in the medical record and if the most recent BMI is ≥ 30 or < 22, a follow-up plan is documented

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. The documentation of a follow up plan should be based on the most recently calculated BMI.

This measure is reported using G-codes:
CPT procedure codes, CPT E/M codes, CPT service codes, HCPCS D-codes, HCPCS G-codes, and patient demographics (age, gender, etc.) 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, submit the appropriate denominator code(s) and the appropriate numerator G-code.

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 ≥ 30 or < 22

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.
Not eligible for BMI measurement – Patients can be considered not eligible in the following situations:

- If the patient already is diagnosed as over or under weight and there is documentation in the medical record that the weight problem 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 Coding:

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

G8420: BMI < 30 AND ≥ 22 was calculated and documented

OR

G8417: BMI ≥ 30 was calculated and a follow-up plan was documented in the medical record

OR

G8418: BMI < 22 was calculated 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 ≥ 30 or < 22, Follow-up Plan not Documented, Reason not Specified

G8421: BMI not calculated

OR

G8419: BMI ≥ 30 OR < 22 was calculated, but no follow-up plan documented in the medical record

DENOMINATOR:

Patients aged 65 years and older

Denominator Coding:

A CPT procedure code, CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

CPT procedure codes, CPT service codes, CPT E/M codes, HCPCS D-codes or HCPCS G-codes: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 97001, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 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, the economic impact of which has been estimated at $117 billion in the U.S. Additionally, elderly patients with unintentional weight loss are at higher risk for infection, depression and death. Older people have special nutritional needs due to age and disease processes and professionals of all disciplines need to help older individuals modify their nutritional status, thereby improving quality of life (American Dietetic Association, Nutrition Screening Initiative, 2002).

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.).

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved clinical outcomes, including improved blood pressure, lipid levels, and glucose metabolism, decreased diabetes incidence, and reduced mortality, but not consistently high quality evidence

Callee, E. E., Thun, M.J., Petrelli, J.M., Rodriquez, C., Heath, C.W., Jr. (1999). "Body-mass index and mortality in a prospective cohort of U.S. adults." New England Journal of Medicine 341: 1097-1105.

BMI of less than 22 kg per m^2 in women and less than 23.5 kg per m^2 in men is associated with increased mortality.

Study quality level 2 (limited-quality patient-oriented evidence)

Corrada, M. M., et al. (2006). “Association of body mass index and weight change with all-cause mortality in the elderly.” American Journal of Epidemiology 163(10): 938-949.

The study explored the relation of BMI and weight change to all-cause mortality in the elderly. Results highlight the influence on older-age mortality risk of being underweight or obese later in life.

Study quality level 2 (limited-quality patient-oriented evidence)

Flegal, K. M., et al. (2005). “Excess deaths associated with underweight, overweight, and obesity.” JAMA 293: 1861-1867.

This study sought to estimate deaths associated with underweight (BMI < 18.5), overweight (BMI 25 to < 30), and obesity (BMI $\geq$ 30) in the United States in 2000. Underweight was associated with 33,746 excess deaths. Underweight and obesity, particularly higher levels of obesity, were associated with increased mortality relative to the normal weight category.

Study quality level 2 (limited-quality patient-oriented evidence)

Jain, M. G., et al. (2005). “Body mass index and mortality in women: Follow-up of the Canadian national breast screening study cohort.” International Journal of Obesity 29: 792-797.

A study designed to examine the relationship between obesity and all-cause mortality in women confirms the association of high BMI with increased all-cause mortality in women.

Study quality level 2 (limited-quality patient-oriented evidence)

McTigue, K. M., et al. (2003). “Screening and interventions for obesity in adults: Summary of the evidence for the U.S. preventive services task force.” Annals of Internal Medicine 139(11): 933-949.

This meta-analysis concludes that counseling and pharmacotherapy can promote modest sustained weight loss, improving clinical outcomes. Weight reduction improved blood pressure, lipid levels, and glucose metabolism and decreased diabetes incidence.

Study quality level 1 (good-quality patient-oriented evidence)