

Universal Weight Screening and Follow-Up

*This measure is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of **once** per reporting period.*

Measure description

Percentage of patients aged 65 years and older with a calculated Body Mass Index (BMI)¹ 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

What will you need to report for each patient aged 65 years and older for this measure?

If you select this measure for reporting, you will report:

- Whether or not a calculated BMI within the past 6 months is documented in the medical record (and if appropriate, a follow-up plan is also documented in the medical record)

Patients will fall into one of three categories described below:

- BMI < 30 AND ≥ 22 was calculated and documented
- BMI ≥ 30 was calculated and a follow-up plan was documented in the medical record
- BMI < 22 was calculated and a follow-up plan was documented in the medical record

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to calculate BMI, due to:

- Documented reasons (eg, documentation in the medical record that the weight problem is being managed by another provider, patient has a terminal illness, patient refuses BMI measurement, patient is in urgent medical situation and to delay treatment would jeopardize the patient's health)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

¹Body Mass Index (BMI) is a number calculated from a person's weight and height. 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. A **calculated BMI** requires that both the height and weight are actually measured. Values reported by the patient cannot be used.

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PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	No	Code Required on Claim Form
Patient is aged 65 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT Procedure Code, CPT Service Code, CPT E/M Service Code, D-code, or G-code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes.
If No is checked for any of the above, STOP. Do not report a G-code.			
Step 2 Does patient meet or have an acceptable reason for not meeting the measure?			
Weight Screening	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
BMI < 30 and ≥ 22 was calculated and documented; no follow-up plan needed	<input type="checkbox"/>	<input type="checkbox"/>	G8420
BMI ≥ 30 was calculated; follow-up plan documented in the medical record	<input type="checkbox"/>	<input type="checkbox"/>	G8417
BMI < 22 was calculated; follow-up plan documented in the medical record	<input type="checkbox"/>	<input type="checkbox"/>	G8418
Not documented for the following reason: • Documented reasons (eg, patient not an eligible for BMI Calculation ¹)	<input type="checkbox"/>	<input type="checkbox"/>	G8422
Document reason here and in medical chart. _____ _____			If No is checked for all of the above, report G8421 (BMI not calculated.) OR G8419 (BMI ≥ 30 or < 22 was calculated, but no follow-up plan documented in the medical record.)

¹Patients may be considered not eligible in the following situations: documentation in the medical record that the weight problem is being managed by another provider, patient has a terminal illness, patient refuses BMI measurement, patient is in urgent medical situation and to delay treatment would jeopardize the patient's health.

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Coding Specifications

Codes required to document a visit occurred:

A CPT procedure code, CPT service code, CPT E/M service code, HCPCS D-code or HCPCS G-code is required to identify patients to be included in this measure.

CPT procedure codes

- 00140, 00142 (anesthesia for procedures on eye),
- 00170 (anesthesia for intraoral procedures),
- 00400, 00402 (anesthesia for procedures on the integumentary system),
- 00810 (anesthesia for lower intestinal endoscopic procedures),
- 00832 (anesthesia for hernia repairs in lower abdomen),
- 00851 (anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy),
- 00910 (anesthesia for transurethral procedures),
- 00920 (anesthesia for procedures on male genitalia),
- 01380, 01382, 01400 (anesthesia for knee joint),
- 01732 (anesthesia for diagnostic arthroscopic procedures of elbow joint),
- 01810 (anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand),
- 01820 (anesthesia for all closed procedures on radius, ulna, wrist, or hand bones),
- 01829 (anesthesia for diagnostic arthroscopic procedures on the wrist)

OR

CPT service codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient),
- 97001, 97003 (physical medicine and rehabilitation),
- 97802, 97803 (medical nutrition therapy)

OR

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home visit)

OR

HCPCS D-codes

- D7140 (extraction, erupted tooth or exposed root),
- D7210 (surgical removal of erupted tooth)

OR

HCPCS G-code

- G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination),
- G0108 (diabetes services),
- G0270 (medical nutrition therapy)

Quality codes for this measure (one of the following for every eligible patient):

G-code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **G8420:** BMI < 30 AND ≥ 22 was calculated and documented
- **G8417:** BMI ≥ 30 was calculated and a follow-up plan was documented in the medical record
- **G8418:** BMI < 22 was calculated and a follow-up plan was documented in the medical record
- **G8422:** Patient not eligible for BMI calculation
- **G8421:** BMI not calculated
- **G8419:** BMI ≥ 30 OR < 22 was calculated, but no follow-up plan documented in the medical record