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Improving Adult BMI Assessment Metric Coding in a Small, Urban Primary Care Setting

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Improving Adult BMI Assessment Metric Coding in a Small, Urban Primary Care Setting

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Improving Adult BMI Assessment Metric Coding in a Small, Urban Primary Care Setting

Abstract

Background: The Adult Body Mass Index (BMI) Assessment measure is defined as the percentage of patients, age 18 to 74, with a documented BMI and weight within the past two years. It is measured using claims data based on current diagnoses coding. The clinic benchmark for this measure is 93%. Baseline data showed the participating clinic (PPCC) to be at 3.6%. A practice improvement project was initiated with the goal of improving Adult BMI Assessment coding from 3.6% to 50%.

Method: The intervention included creation of a coding cheat sheet, placement of BMI charts with ICD-10 BMI codes in examination rooms, and education of providers and Medical Assistants (MA) concerning Adult BMI Assessment coding and its importance for patients and reimbursement. Chart review was used to identify the number of patients seen, the number of patients with a documented height/weight/BMI, and the number of patients with a documented ICD-10 BMI code during an 8-week period between September 2016 and November 2016. Percentages of patients with a documented ICD-10 BMI code were calculated each week.

Results: Throughout implementation, the percentage of patients with a documented ICD-10 BMI code fluctuated. In week 7, the goal of 50% was obtained with 52% of patients having a documented ICD-10 BMI code.

Discussion: Use of ICD-10 code cheat sheets can improve documentation and increase metric scores to improve reimbursement opportunities.

Keywords: practice improvement, metrics, coding, ICD-10, primary care

Improving Adult BMI Assessment Metric Coding in a Small, Urban Primary Care Setting

Introduction

Background

In primary care, metrics are often used independently to assess performance, provide purpose for actions, and promote informed practice change (Stange et al., 2014). Primary care clinics that are members of Coordinated Care Organizations (CCO) use metrics to determine if the clinic is effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs (Oregon Health Authority [OHA], n.d.). PPCC is a primary care clinic that participates in a CCO and serves predominantly Medicaid recipients. It is a small clinic with two providers and two MAs. As a member of the CCO, PPCC submits five chosen incentive metrics for reimbursement and monitoring of their Medicaid members.

In 2016, PPCC selected the Healthcare Effectiveness and Data Information Set (HEDIS) measure of Adult Body Mass Index (BMI) Assessment as one of its five core metrics. This measure, created in 2009, is part of the Centers for Medicaid and Medicare Services (CMS) 5-star measures (CMS, 2015). The Adult BMI Assessment measure, defined as the percentage of patients, age 18 to 74, with a documented BMI and weight at the same clinic visit within the past two years, uses claims data based on ICD-10 coding of a specific BMI (CareOregon, 2015). At the start of this project, the providers and clinic manager were unaware the metric was measured using ICD-10 coding. Baseline data collected in September 2016 showed PPCC's Adult BMI Assessment measure to be 3.6% based on chart auditing of ICD-10 BMI coding. The lack of ICD-10 BMI documentation has the potential to cause monetary penalization for the clinic.

Assessing and monitoring patient BMI is imperative for the management of weight and weight related health conditions. Obesity is a major risk factor for several leading causes of preventable morbidity and mortality (Kushner, 2012; STOP Obesity Alliance Research Team, 2010) and is linked to a higher use of health care services, as well as higher health care costs (United States Preventive Services Task Force [USPSTF], 2012). Medical expenditures attributable to obesity range from $1143 to $6684 per person (Kushner, 2012). This greatly affects Medicaid populations as there is a positive correlation between obesity and poverty, with Medicaid recipients generally having a higher prevalence of obesity and associated medical expenditures than non-Medicaid recipients (Lemay, Cashman, Savageau, & Reidy, 2004; Rose, Gokun, Talbert, & Conigliaro, 2013).
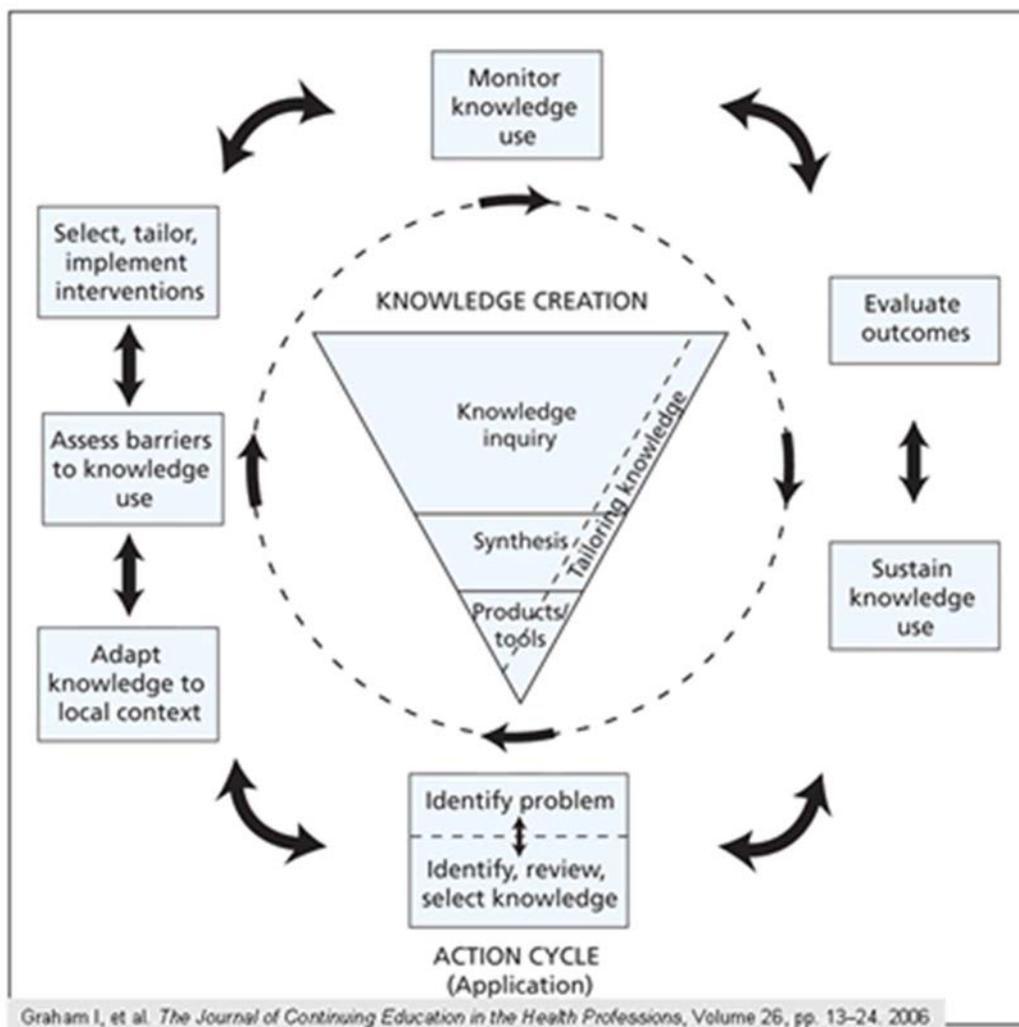
For the purpose of this practice improvement/ quality improvement project, PPCC focused on improving ICD-10 BMI documentation to meet a starting benchmark of 50% over an 8 week period project. After the 8 weeks, PPCC can begin a new action cycle and eventually meet the CMS benchmark for the Adult BMI Assessment metric which is 93%. Meeting the CMS benchmark improves PPCC's ability for reimbursement of their Oregon Health Plan/Medicaid patients, and improves the providers' ability to begin conversations with patients regarding weight and healthy lifestyle choices in order to obtain or maintain a normal BMI.

Methods

Implementation Model

The Knowledge to Action Model (*Figure 1)* was chosen to guide the implementation of this practice change. The Knowledge to Action Model, developed by Grahm et al. (2006) at the University of Ottawa, represents the translation of knowledge into practice via knowledge

creation and knowledge application (White, 2012a). The model is intended for use in a wide

range of practice domains (White, 2012a), making it an appropriate model for use in the PPCC

environment.

Monitor
knowledge
use

Select, tailor,
implement
interventions

Assess barriers
to knowledge
use

Adapt
knowledge to
local context

KNOWLEDGE CREATION

Knowledge
inquiry

Synthesis

Tailoring knowledge

Products/
tools

Evaluate
outcomes

Sustain
knowledge
use

Identify problem

Identify, review,
select knowledge

ACTION CYCLE
(Application)

Graham I, et al. *The Journal of Continuing Education in the Health Professions,* Volume 26, pp. 13–24. 2006

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Figure 1: Knowledge to action cycle. This figure is a pictorial representation of the steps in the

knowledge to action model of implementation.

The central part of the model focuses on knowledge creation *(Figure 1),* while the outer

portion illustrates application of knowledge in practice (White, 2012a). Using this model, a lack

of knowledge of metric measurement and use of ICD-10 codes associated with BMI was

identified as a problem. Next, a literature search was performed to identify potential evidence-based interventions used in other healthcare settings to improve ICD-10 coding practice.

Using the databases of Medscape and the Cumulative Index of Nursing and Allied Health Literature (CINAHL), seven articles on improving BMI documentation were found. None were found on improving provider coding practices. The quality of evidence present in the literature was low as the articles found were site-specific quality improvement projects with varied suggestions on how to improve BMI documentation. The most common suggestions were chart prompting and EMR implementation (Bode, Roberts, & Johnson, 2013; Keehbauch et al., 2012; Bordowitz, Morland, & Reich, 2007), protocol education (Greenwood, Narus, Leiser, & Egger, 2010), and multi-intervention approaches that included education and tailoring the clinic environment to improve documentation (Laiteerapong et al., 2011; Lemay, Cashman, Savgeau, & Reidy, 2004).

Intervention

After a review of the literature and synthesis of the evidence, the above suggestions for improving documentation were presented to the clinic manager. Through discussions with providers, MAs, and the clinic manager, potential barriers for these suggestions were discussed (e.g. PPCC is a small clinic lacking the resources to spend on EMR updates). From these discussions, a multi-intervention approach was selected as the best option, and was tailored to meet PPCC's needs and clinic environment. This was achieved through the creation of coding cheat sheets and BMI charts with ICD-10 codes for use as coding reminders and aids. The cheat sheets are shown below. Education on the importance of the Adult BMI Assessment metric, how it is measured, and the importance of accurate documentation for reimbursement was given to

providers, MAs, and clinic staff. Prior to implementation, IRB approval and provider/MA consent was obtained.

BMI Coding Cheat Sheet

Adult BMI Assessment

About the metric:

- One of the Medicare Star Measures

- Percentage of patients between the ages of 18 and 74 who had their BMI calculated and recorded in their record

Measurement:

- Members 21 and older who had their *weight and BMI value* documented: Or younger than 21 years of age, have *weight and BMI percentile* **Divided BY** All patients of the clinic between the ages of 18 and 74

- Exclusions: pregnancy

How is it being measured?

- Using claims data based on coding for the assessment

What needs to be documented?

- 21-74: Weight and BMI value dated within the past two years-must be from the same data source (i.e. same patient visit).

- 18-21: Height, weight and BMI percentile-must be from the same data source (i.e. same patient visit).

Codes that count:

BMI ICD-10: Z68.1, Z68.20-Z68.45

BMI Percentile: Z68.51-Z68.54

BMI Coding Cheat Sheet Cont.

What the Codes Mean

BMI ICD-10 Adult:

Z68.1 = BMI of 19 or less

Z68.20 - Z68.29 = these correspond with BMI of 20.0-29.9; E.G. a patient's BMI is 24 –

the code entered would be Z68.24

Z68.30 - Z68.39 = these correspond with BMI of 30.0-39.9; E.G. a patient's BMI is 36.4-

the code entered would be Z68.36

Z68.40 = BMI of 40 or greater

Z68.41 = BMI of 40.0 - 44.9

Z68.42 = BMI of 45.0 – 49.9

Z68.43 = BMI of 50.0 – 59.9

Z68.44 = BMI of 60.0 – 69.9

Z68.45 = BMI of 70 or greater

BMI Percentile ICD-10 Pediatric:

Z68.51 = less than 5th percentile for age

Z68.52 = 5th percentile to less than 85th percentile for age

Z68.53 = 85th percentile to less than 95th percentile for age

Z68.54 = greater than or equal to 95th percentile for age

BMI Chart with Coding Ranges

MAYO CLINIC HEALTH SYSTEM

Body Mass Index (BMI)

	HEALTHY						OVERWEIGHT					OBESITY										EXTREME OBESITY										
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
HEIGHT												WEIGHT (IN POUNDS)																				
4'10"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239
4'11"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247
5'	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255
5'1"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264
5'2"	104	109	115	120	126	131	136	142	147	153	158	164	169	174	180	185	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273
5'3"	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	192	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282
5'4"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291
5'5"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300
5'6"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309
5'7"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319
5'8"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328
5'9"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338
5'10"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348
5'11"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358
6'	140	147	154	162	169	177	184	191	199	206	213	221	228	235	243	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368
6'1"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378
6'2"	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389
6'3"	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399
6'4"	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410

← REDUCED RISK   INCREASED RISK →

Health Risks Associated with Obesity

____ Insulin resistance *(type 2 Diabetes)* ____ High blood pressure ____ Depression
____ Elevated cholesterol ____ Coronary heart disease ____ Premature death
____ Sleep apnea ____ Stroke ____ Other _____
____ Osteoarthritis ____ Many types of cancer

5104 PA 6/12

Image: (Mayo Clinic Health Systems, 2012, http://www.innerimage.com/resources/interpreting-your-results/) *COPYRIGHTED MATERIAL: PERMISSION REQUIRED

Adult BMI ICD 10 Codes:
Z68.1 = BMI of 19 or less
Z68.20 - Z68.29 = these correspond with BMI of 20.0-29.9
Z68.30 - Z68.39 = these correspond with BMI of 30.0-39.9
Z68.40 = BMI of 40 or greater
Z68.41 = BMI of 40.0 - 44.9
Z68.42 = BMI of 45.0 – 49.9
Z68.43 = BMI of 50.0 – 59.9
Z68.44 = BMI of 60.0 – 69.9
Z68.45 = BMI of 70 or greater

Data Collection and Measures

Weekly chart reviews were performed to monitor knowledge use and regularly evaluate outcomes. Charts of patients seen during the week who met the inclusion criteria were audited for documentation of height, weight, BMI, and an ICD-10 BMI code at the same visit within the past two years. During baseline data collection, it was noted providers often used the ICD-10 code of Obesity not Specified (E69). This code is not recognized by Care Oregon for the Adult BMI Assessment measure. The use of this ICD-10 code was recorded weekly as an incorrectly coded BMI.

The Knowledge to Action Model (*Figure 1)* suggest monitoring knowledge use through formative evaluation. This was completed through scheduled check-ins with the providers, MAs, and office manager weekly. During these check-ins, providers, MAs, and the office manager were asked three questions: 1) How do you think improving the Adult BMI Assessment screening rates is going?, 2) Have you found any barriers, workarounds, or success to improving screening rates this week?, 3) Do you have any suggestions, concerns or questions about this practice change? Answers to these questions were utilized as feedback. Suggestions that were made were shared with the group and the office manager approved changes to further improve the Adult BMI Assessment screening documentation.

Results

Figure 2 shows the total number of patients seen each week, the number of heights, weights, and BMIs recorded, and the number of correct ICD-10 BMI diagnoses. Height, weight, and BMI were documented for over 90% of patients seen each week. The number of ICD-10 coded BMIs fluctuated over the course of data collection. At baseline, 3.6% of BMIs were coded. This percentage rose to 20% during week 1 following the intervention. During week 2

and 3, the percentage of patients with a coded ICD-10 BMI decreased to 10%. During weeks 4,

5, 6, and 7, the percentage of patients with a coded ICD-10 BMI steadily rose to a cap of 52%.

This percentage decreased to 43% again in week 8.
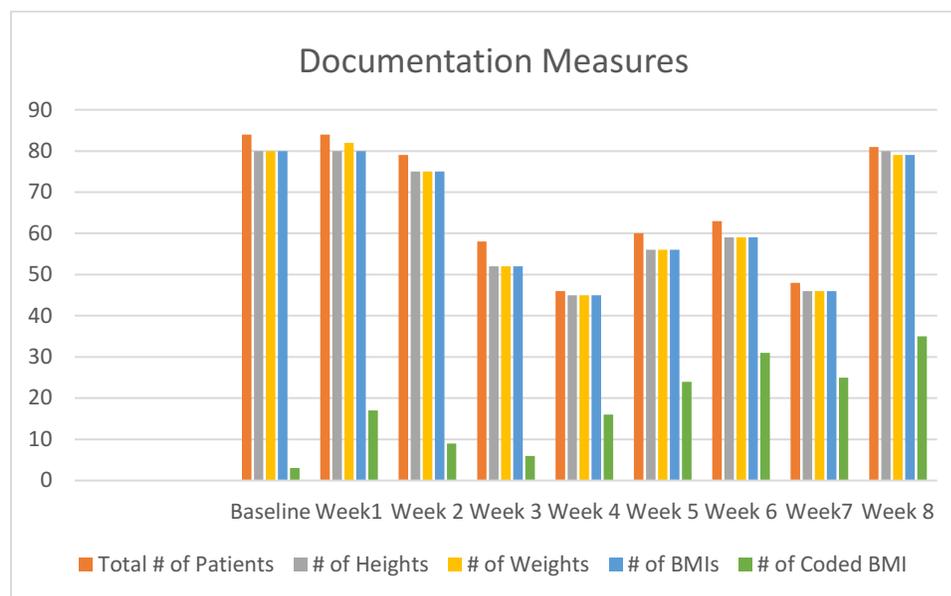
Figure 2: Documentation Measures. This graph represents the weekly totals of number of patients

seen, number of heights/weights/BMIs recorded, and the number of patients with a correctly

coded ICD-10 BMI diagnosis code.

Figure 3 shows the percentage of patients with a correct ICD-10 BMI diagnosis code

compared to the total number of patients seen each week. As stated above, this percentage

fluctuated over the data collection period. During week 1, the number of patients with a

documented ICD-10 BMI increased from 3.6% to 20%. In week 7, the percentage of patients

with a documented ICD-10 BMI caped at 52%. Reasons for these fluctuations are explored

below in the discussion.
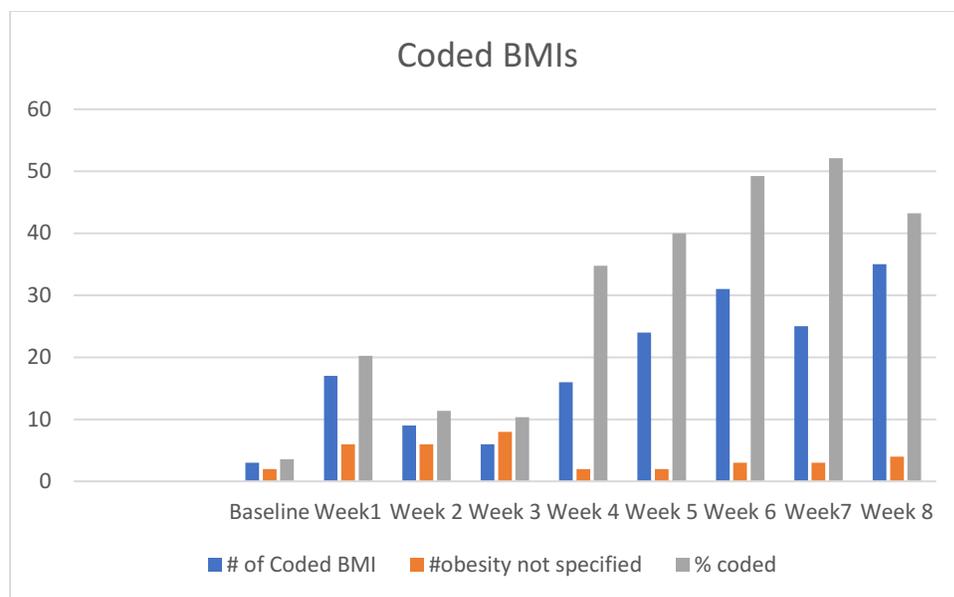
Figure 3: Coded BMIs. This graph shows the number of correctly documented ICD-10 BMI codes, the number of patients with incorrectly documented ICD-10 BMI codes, and the percentage of patients with a correctly documented ICD-10 BMI diagnosis code.

Discussion

Baseline measurements showed only 3.6% of patients had a correct ICD-10 code for BMI. During the first week of implementation, the percent of patients with a recorded height, weight, and BMI remained the same, but the percentage of patients with an ICD-10 code for BMI increased to 20%. Over the next two weeks, ICD-10 codes for BMI decreased to about 10%. This was possibly due to one of two providers being absent for those two weeks. Based on this decrease, the clinic manager asked if one MA would assume the responsibility of documenting ICD-10 BMI codes for patients seen by her assigned provider, i.e. one provider documented codes for patients she saw, while the other provider had her MA document the codes. Consequently in week 4 of implementation, the percentage of patients with a coded BMI for that week went up to 34.8%. Over the next 4 weeks, this percentage continued to increase,

hitting a maximum of 52% in week 7 and dropping back to 43% in week 8. This could possibly be due to the MA being gone for two days during that week.

It is important to note that patient height, weight, and BMI were documented in over 90% of patient visits each week. These numbers did not change during the implementation process. The practice change was geared towards increasing the percentage of patients with a documented ICD-10 code for BMI, not improving documentation of height, weight, or BMI.   During the eight weeks of data collection, the percentage rose from a baseline of 3.6% to a height of 52.1 %. This is a clinically significant increase. However, the percentage of patients with an ICD-10 BMI specific code remains well below the CMS benchmark of 93%. Possible contributing factors to the low coding rate include provider absence, MA absence, and the holiday season.

Process data was also collected throughout the implementation. Feedback around the cheat sheets and in-room BMI charts was primarily positive, with most saying that these items were helpful for documentation. The providers and MAs also stated having easy access to these codes made it more likely they would document ICD-10 codes. Providers stated the in-room BMI charts also served as a visual reminder for them. However, providers suggested the topic of BMI did not always come up during patient visits, especially if they were focused visits surrounding a specific complaint and had limited time to meet with the patient. This decreased the likelihood of them charting an ICD-10 code for BMI on that patient. Providers and the clinic manager also shared that many patients did not come in for annual wellness exams or follow up after receiving focused care. During these wellness and follow up examinations, providers have time to discuss health prevention and promotion, including information about BMI and healthy weight. Additional feedback from the MA who took on the responsibility of charting ICD-10 BMI codes in week 4 highlighted an area for further improvement by stating "I would be able to

enter more ICD-10 BMI codes if the provider I worked with did not sign off on the charts so quickly". These barriers could be addressed through use of a Plan-Do-Study-Act (PDSA) cycle, that would aid in increasing ICD-10 BMI coding documentation to meet the current CMS 5-Star benchmark.

Conclusion

In primary care, metrics are often used independently to assess performance, provide purpose for actions, and promote informed practice change (Stange et al., 2014). In 2016, PPCC selected the HEDIS measure of Adult BMI Assessment as one of its five core metrics to report for patient monitoring and reimbursement. It is measured through billing claims data associated with an ICD-10 code. At the start of this project, the providers and clinic manager were unaware the metric was measured using ICD-10 coding. Baseline data collected in September 2016 showed PPCC's Adult BMI Assessment measure to be 3.6% based on chart auditing ICD-10 BMI diagnoses codes.

To improve BMI diagnoses coding from 3.6%, coding cheat sheets and BMI charts with ICD-10 codes were created. These were used by providers and MAs as a reminder and aid in documenting correct BMI diagnoses codes. Education concerning these aids and the importance of the Adult BMI Assessment metric was provided to providers, MAs, and clinic staff. These practice changes were implement using the Knowledge to Action Model of Implementation (*Figure 1)*. A clinically significant improvement was noted throughout the eight week data collection process. The percentage of patients with an ICD-10 BMI diagnosis code rose from 3.6% to a high of 52.1%. However, this is still well below the CMS benchmark of 93%. Continued improvement possibly be made with additional education, reminders, or alterations to the coding aids through the use of a quality improvement PSDA cycle.

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