

## Body Mass Index (BMI) Assessment (BAA)

### SUMMARY OF CHANGES TO HEDIS 2009

- First-year measure.

#### Description

The percentage of members 18–74 years of age who had an outpatient office visit and who had their body mass index (BMI) documented.

#### Definitions

<b>BMI</b>	Body Mass Index (BMI) is calculated from a person's height and weight. The calculation is based on the following formulas. <ul style="list-style-type: none"> <li>• Weight (kg) / [height (m)]<sup>2</sup> <b>or</b></li> <li>• (Weight (lb) x 703) / [height (in)]<sup>2</sup></li> </ul>
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#### Eligible Population

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	None.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	Members who had an outpatient visit (Table BAA-A) during the measurement year or the year prior to the measurement year.

**Table BAA-A: Codes to Identify Outpatient Visits**

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99499			051x, 0520-0523, 0526-0529, 077x, 0982, 0983
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, 99429	G0344		0770, 0771, 0779
Clinic				051x
Freestanding clinic				052x
Professional fees, outpatient services				0982
Professional fees, clinic				0983
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

**Administrative Specification**

**Denominator** The eligible population.

**Numerator** BMI assessed (Table BAA-B) during the measurement year or year prior to the measurement year.

**Table BAA-B: Codes to Identify BMI**

Description	ICD-9 Codes
BMI	V85.0-V85.4

**Hybrid Specification**

**Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year’s administrative data.

**Numerator** BMI during the measurement year or year prior to the measurement year as documented through either administrative data or medical record review.

**Administrative** Refer to the *Administrative Specification* to identify positive numerator hits from the administrative data.

**Medical record** Documentation in the medical record must indicate the following.

- A note indicating the date the assessment was performed, **and**
- The result or finding (the calculated BMI).

For members who are 18 years old when BMI is documented, documentation of a BMI value expressed as kg/m<sup>2</sup> or BMI percentile documented as a value (e.g., 85th percentile for age/gender) or plotted on an age-growth chart is acceptable.

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**Exclusions (optional)**

Exclude from the eligible population all members (Table BAA-C) who are pregnant during the measurement year or year prior to the measurement year.

**Table BAA-C: Codes to Identify Exclusions**

Description	ICD-9-CM Diagnosis
Pregnancy	630-677, V22, V23, V28

**Note**

- The organization may calculate BMI from a height and weight documented in the medical record or from other sources (e.g. health risk assessment) using either of the following formulas.
  - Weight (kg) / [height (m)]<sup>2</sup> or
  - (Weight (lb) x 703) / [height (in)]<sup>2</sup>

The organization must calculate the BMI and document it in the medical record by the deadline established by the measure (December 31 of the measurement year). The documentation must include the date the height and weight were measured, the date the calculation was performed and the result (BMI).

**Data Elements for Reporting**

An MCO that submits HEDIS data to NCQA must provide the following data elements.

**Table BAA-1/2: Data Elements for BMI Assessment (Adults)**

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

## Proposed New Measure for HEDIS 2009: Body Mass Index (BMI) Assessment (BAA) Measure Work-Up

Information Required	Comment/Standardized Answer
<b>ABSTRACT/IDENTIFYING INFORMATION</b>	
<b>Body Mass Index (BMI) Assessment (BAA)</b>	
<p><i>Measure Collection:</i> Identifies the name of the collection of measures to which the measure belongs (if applicable).</p>	<p>This measure is under development for consideration of inclusion in HEDIS® and NCQA Provider Recognition Programs</p>
<p><i>Measure Description:</i> A concise statement about the measure that includes the specific aspects of healthcare addressed, the level of analysis, care or service settings, the time period the measure addresses (e.g., daily, yearly, monthly).</p> <p><i>Measure History:</i> Past and current state of use of the measure; how long the measure has been used; the vetting process to ensure the integrity of the measure (e.g., use of technical advisory panels, Public Comment period) and any publications of studies (or in public reporting programs, such as the state) in which the performance of the measure is demonstrated.</p>	<p><input type="checkbox"/> Publications list attached</p> <p><input checked="" type="checkbox"/> There are no publications in which this measure was used.</p> <p><input checked="" type="checkbox"/> Measure has only been field-tested.</p> <p><i>Description:</i> The percentage of members 18–74 years of age who had an outpatient office visit and who had their body mass index (BMI) documented.</p> <p><i>Measure History:</i> This measure was field-tested in the summer 2007. NCQA convened an Adult Obesity Measurement Advisory Panel (MAP), consisting of experts in the field of adult obesity, measurement methodology and health services research to advise on the development of performance measures focused on adult obesity. The measure is the first step toward developing a spectrum of metrics focused on adult obesity and, if determined feasible, valid and reliable, may be incorporated at the plan and physician levels.</p>
<b>IMPORTANCE</b>	
<p><i>Measure Rationale:</i> The importance of this measure (i.e., why it is used). The rationale should incorporate relevant statistics that illustrate the cost or burden of poor quality in this area and the availability of accepted tools, practices or information for improvement.</p>	<p><input type="checkbox"/> Replacement for a currently NQF-endorsed™ measure (provide name of measure)</p> <p><input type="checkbox"/> Complement to a currently NQF-endorsed™ measure (please provide name of measure)</p> <p><input checked="" type="checkbox"/> No prior existing measure</p> <p><input type="checkbox"/> Other _____</p> <p>Guidelines from various organizations, including the Institute for Clinical Systems Improvement (ICSI), U.S. Preventive Services Task Force (USPSTF), National Heart, Lung, and Blood Institute (NHLBI), and the Michigan Quality Improvement Consortium, indicate that the first step in weight management is assessment of height and weight in order to calculate a patient's BMI. BMI is the most efficient and practical method for assessing excess body fat. It is a starting point for assessing the relationship between weight and height, and it is the most conducive method of assessment in the primary care setting (NHLBI 2001).</p> <p>It is estimated that the aggregate costs of obesity range from 5%–7% of the total annual medical expenditures in the United States (\$75 billion per year) (Finkelstein 2003, 2005). The cost of obesity to U.S. business in 1994 was estimated to total \$12.7 billion–\$10.1 billion due to moderate or severe obesity and \$2.6 due to mild obesity. Research has attributed billions in business expenditures to obesity, including paid sick leave and life and health insurance, totaling \$2.4 billion, \$1.8 billion, and \$800 million respectively (Thompson, 1998) Not only is the prevalence of obesity increasing, but the relative per capita spending on obese</p>

Information Required	Comment/Standardized Answer
<b>IMPORTANCE</b>	
	<p>Americans is also increasing. That increase accounts for 27% of the growth in real per capita spending between 1987 and 2001. The increase spending is due to two trends: the increase in obesity prevalence and the increase in spending on the obese, relative to those of normal weight (Thorpe 2004). Within that same time frame, the prevalence of obesity increased by 10.3 percentage points to almost 24% of the adult population (Thorpe 2004). This rise in obesity is directly correlated to drastic increases in the incidence of three major conditions: diabetes, hyperlipidemia and heart disease.</p> <p><i>References</i></p> <p>Finkelstein, E.A., I.C. Fiebelkorn, G. Wang. National medical spending attributable to overweight and obesity: how much, and who's paying? <i>Health Aff Suppl.</i> 2003. W3-219-26.</p> <p>Finkelstein, E.A., C.J. Ruhm, K.M. Kosa. Economic causes and consequences in obesity. <i>Annu Rev Public Health.</i> 2005. 26:239-257.</p> <p>Thompson, D., J.B. Brown, et al. Estimated economic costs of obesity to U.S. business. <i>Am J Health Promot.</i> 1998. 13(2):120-127.</p> <p>Thompson D., J.B. Brown, et al. Body mass index and future healthcare costs: a retrospective cohort study. <i>Obes Res.</i> 2001. 9(3):210-218.</p> <p>Thorpe, K., C. Florence, D. Howard, P. Joski. The Impact of Obesity on Rising Medical Spending, <i>Health Affairs Web Exclusive.</i> October 20, 2004.</p>
<p><b>Key Leverage Point:</b> Provides a description of the current gap between actual and potential performance that allows room for improvement. Key leverage point includes description of:</p> <ul style="list-style-type: none"> <li>• <b>Variation in quality.</b> Geographic, demographic, coverage, or other factors.</li> <li>• <b>Significant opportunity for improvement.</b> Performance in the area is substandard, and thus significant opportunity exists for improvement. This may be independent of variation, in cases where quality is consistently poor.</li> <li>• <b>Relevance to consumers or purchasers (e.g., safety concerns).</b> Variation in costs/ resource utilization (i.e., underuse, overuse or misuse).</li> </ul>	<p>Obesity is the second leading cause of preventable death in the United States. It is a complex multifaceted chronic disease that is impacted by environmental, genetic, physiological, metabolic, behavioral and psychological components. Currently, there are approximately 127 million adults in the U.S. who are overweight, 60 million who are obese and 9 million who are severely obese (AOA 2005). Obesity affects individuals from every ethnic group, socioeconomic class and geographic region of the U.S. This disease has been growing by epidemic proportions, with prevalence increasing by approximately 50% per decade. Not only has the prevalence increased, but obesity's impact on individual overall health has drastically increased as well. Obesity increases both morbidity and mortality rates, in addition to increasing the risk for conditions such as diabetes, coronary heart disease and cancer. Obesity has been shown to have a substantial negative effect on longevity, reducing the lifespan of people who are severely obese by an estimated 5–20 years (Olshansky 2005). Excess weight and obesity are contributing causes to more than 50% of all-cause mortality among American adults aged 20–74 years, which results in a significant economic impact—approximately \$99.2 billion is spent annually on obesity-related medical care and disability in the U.S (Thomas 2003).</p> <p>Obesity elevates the risk of diabetes, coronary artery disease, cancer and other conditions. The lifetime risk of diabetes among people born in the U.S. has increased from 30% to 40%, and this increase is directly attributable to the obesity epidemic (Olshansky, 2005) The increased risk of diseases such as diabetes and cardiovascular disease directly shortens life expectancy. For instance, having diabetes in adulthood increases the risk of a heart attack as much as having a previous heart attack, and diabetes shortens life expectancy by approximately 13 years (Olshansky, 2005). Facts suggest that the prevalence and severity of obesity and its complications (comorbidities) will worsen and the rates of obesity-induced death will rise: the prevalence of obesity is expected to rise, especially among children; the distribution of the current overweight and obese adult populations are drastically shifting, with more and more adults moving from mild to moderate/severe BMI levels; and obesity is becoming a long-term problem, with children and young adults carrying obesity-related risks for more of their life compared to previous generations (Olshansky, 2005).</p> <p>Despite the significant impact of overweight and obesity on the U.S. population, surveys indicate physicians are not routinely assessing body mass during office visits, nor are they offering advice to obese adults to lose weight. Physicians report that they often fail to counsel patients regarding weight, diet, or exercise and often do not assess body mass during office visits (Jackson, 2005).</p>

Information Required	Comment/Standardized Answer
<b>IMPORTANCE</b>	
	<p><b>References</b></p> <p>American Obesity Association, AOA Fact Sheets: <i>What is Obesity; Obesity in the U.S.; and Health Effects of Obesity.</i> <a href="http://www.obesity.org/subs/fastfacts/aoafactsheets.shtml">http://www.obesity.org/subs/fastfacts/aoafactsheets.shtml</a>. March 2005.</p> <p>Hedley, A.A., C.L. Ogden, et al. Prevalence of Overweight and Obesity Among US Children, Adolescents, and Adults, 1999-2002. <i>JAMA</i>. 2004. 291:2847-2850.</p> <p>Jackson, J.E., Doescher, M.P., et al. Trends in Professional Advice to Lose Weight Among Obese Adults, 1994 to 2000. <i>J Gen Intern Med</i>. 2005. 20:814-818.</p> <p>Lakadawalla, D.N., D.P. Goldman, B. Shang. The health and cost consequences of obesity among the future elderly. <i>Health Affairs—Web Exclusive</i>. September 26, 2005: W5-R30-R41.</p> <p>Olshansky, S., D. Passaro, et al. A Potential Decline in Life Expectancy in the United States in the 21st Century. <i>New England Journal of Medicine</i>. 2005. 352:11: 1138-1145.</p> <p>Thomas, A., B. Hodges, et al. <i>Obesity in Women: A Guide to Assessment and Management.</i> Brigham and Women's Hospital, Boston, MA. <a href="http://www.brighamandwomens.org/medical/guidelines.asp">http://www.brighamandwomens.org/medical/guidelines.asp</a>. 2003.</p>
<b>SCIENTIFIC ACCEPTABILITY</b>	
<p><b>Evidence Supporting Measure Domain Selected:</b> Supporting evidence appropriate for the measure domain.</p> <ul style="list-style-type: none"> <li>• For <b>access measures</b>, evidence that an association exists between the access measure and the outcomes of, or satisfaction with care.</li> <li>• For <b>outcome measures</b>, evidence that the outcome measure has been used to detect the impact of one or more clinical interventions.</li> <li>• For <b>patient experience measures</b>, evidence that an association exists between the measure of patient experience of health care and the values and preferences of individuals/the public.</li> <li>• For <b>process measures</b>, evidence that the measured clinical or administrative process let to improved health or cost/benefit.</li> <li>• For <b>structural measures</b>, evidence that an association exists between the structure measure and on six aims for quality improvement (safe, beneficial, patient-centered, efficient, timely, equitable).</li> </ul>	<p><input checked="" type="checkbox"/> Evidence Attached <input type="checkbox"/> Evidence not available</p> <p><b>Guideline Recommendations</b></p> <p><b>Institute for Clinical Systems Improvement (ICSI).</b> The ICSI Prevention and Management of Obesity (mature adolescents and adults) guideline recommends that clinicians measure height, weight and calculate BMI preferably annually for screening and as needed for management. Key points considered with respect to BMI are that health consequences exist across BMI span and obesity is a multi-factorial chronic disease (ICSI 2006).</p> <p><b>United States Preventive Services Task Force (USPSTF).</b> The USPSTF recommends that clinicians should screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. The USPSTF found good evidence that BMI is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. Techniques such as bioelectrical impedance, dual-energy X-ray absorptiometry and total body water can measure body fat, but it is impractical to use them routinely. BMI, which is simply weight adjusted for height, is a more practical and widely-used method to screen for obesity. Increased BMI is associated with an increase in adverse health effects. The USPSTF found no randomized controlled trials (RCTs) evaluating the efficacy of obesity screening programs in improving the clinical outcomes of mortality, morbidity, mental health, or functioning (USPSTF 2003).</p> <p><b>National Heart, Lung, and Blood Institute (NHLBI).</b> The NHLBI Practice Guide recommends that clinicians measure height and weight so that patients' BMI can be estimated. Additionally, NHLBI recommends that overall risk take account of the potential presence of other risk factors. Some diseases or risk factors associated with obesity place patients at a high absolute risk for subsequent mortality which will require aggressive management (NHLBI 1998, 2001).</p>

Information Required	Comment/Standardized Answer	
<b>SCIENTIFIC ACCEPTABILITY</b>		
	<p><b>Michigan Quality Improvement Consortium (MQIC).</b> The Michigan Quality Improvement Consortium’s Assessment of BMI begins first with measuring weight and calculating a patient’s BMI to determine if a patient is overweight or obese and patterns of weight change. The Michigan Consortium also recommends assessment of comorbidities and assessing current eating, exercise behaviors, history of weight loss attempts and psychological factors contributing to weight gain (Michigan 2005).</p> <p><b>References</b>                      Centers for Disease Control and Prevention (CDC). Public Health Strategies for Preventing and Controlling Overweight and Obesity in School and Worksite Settings: A Report on Recommendations of the Task Force on Community Preventive Services. <i>Morbidity and Mortality Weekly Report</i>. October 7, 2005; 54:No. RR-10. <a href="http://www.cdc.gov">www.cdc.gov</a>                      Institute for Clinical Systems Improvement (ICSI). <i>Prevention and management of obesity (mature adolescents and adults)</i>. Bloomington (MN): ICSI; 2006 Nov.                      Michigan Quality Improvement Consortium. <i>Identification, evaluation, and treatment of overweight and obesity in the adult</i>. Southfield (MI): Michigan Quality Improvement Consortium; 2005 Mar.                      NHLBI. <i>Clinical Guidelines: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: Evidence Report</i>. U.S. Department of Health and Human Services. Public Health Service. National Institutes of Health. 1998. NIH Pub No: 00-4083.                      NHLBI. <i>The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity</i>. U.S. Department of Health and Human Services. Public Health Service. National Institutes of Health. 2001. NIH Pub No: 00-4084.</p>	
<p><b>Data Source:</b> The data source necessary to implement the measure (e.g., administrative data only, clinician survey, medical record only, patient survey only or a hybrid method).</p> <ul style="list-style-type: none"> <li>• Specifications for using data sources should be described</li> <li>• If more than one data source can be used to calculate the measure, evidence supporting the comparability of the sources should be provided.</li> <li>• For EHRs, provide any additional detail necessary specific for use of the measure in this medium.</li> </ul>	<input type="checkbox"/> Administrative and laboratory data <input checked="" type="checkbox"/> Administrative and medical record data <input type="checkbox"/> Administrative and pharmacy data <input type="checkbox"/> Administrative and provider data <input type="checkbox"/> Administrative data only <input type="checkbox"/> Administrative and clinician survey <input type="checkbox"/> Administrative and patient survey <input type="checkbox"/> Clinician survey only	<input type="checkbox"/> Patient survey only <input type="checkbox"/> Laboratory data only <input type="checkbox"/> Medical record data only <input checked="" type="checkbox"/> Paper medical record <input checked="" type="checkbox"/> Electronic health record <input type="checkbox"/> Observational data (e.g., compliance measures that require observation of practices) <input type="checkbox"/> Other _____
<p><b>Denominator Inclusions/Exclusions:</b> The specific inclusion and exclusion criteria used to refine the denominator. Include all relevant codes (e.g., ICD-9, CPT, G-codes).</p>	<p><b>Exclusions:</b></p> <input type="checkbox"/> Contraindications <input type="checkbox"/> Age <input type="checkbox"/> Comorbid conditions  <p><b>Inclusions:</b> 18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year. Only adult members who have an office visit during the measurement year or the year prior to the measurement year.</p>	<input type="checkbox"/> Stage of Illness <input type="checkbox"/> Time of index event <input checked="" type="checkbox"/> Other—Pregnancy

Information Required	Comment/Standardized Answer
<b>SCIENTIFIC ACCEPTABILITY</b>	
<p><b>Denominator Time Window:</b> Classifies the time period (in association with the denominator index event) in which patients are reviewed for inclusion in the denominator.</p>	<p>Annually.</p>
<p><b>Numerator Event:</b> Identifies the event or state that defines a patient eligible for inclusion in the numerator (e.g., clinical condition, diagnostic encounter, office visit, hospitalization).</p>	<p>A BMI was measured and documented during the measurement year or year prior to the measurement year.</p>
<p><b>Numerator Inclusions/Exclusions:</b> The specific inclusion and exclusion criteria used to refine the numerator. Exclusions related to patient preferences should also be included where appropriate.</p>	<p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Contraindications</li> <li><input type="checkbox"/> Age</li> <li><input type="checkbox"/> Comorbid conditions</li> <li><input type="checkbox"/> Stage of illness</li> <li><input type="checkbox"/> Time of index event</li> <li><input checked="" type="checkbox"/> Other—Plan calculated BMI that is not included in the provider medical record</li> </ul> <p><b>Inclusions:</b> BMI during the measurement year or year prior to the measurement year as documented through either administrative data or medical record review.</p> <p>Documentation in the medical record must indicate the following.</p> <ul style="list-style-type: none"> <li>• A note indicating the date the assessment was performed, <i>and</i></li> <li>• The result or finding (the calculated BMI)</li> </ul> <p>For members who are 18 years old when BMI is documented, documentation of a BMI value expressed as kg/m<sup>2</sup> or BMI percentile documented as a value (e.g. 85th percentile for age/gender) or plotted on an age-growth chart is acceptable.</p>
<p><b>Numerator Time Window:</b> Identifies the time period in which patients are reviewed for inclusion in the numerator.</p>	<p>At least once during the measurement year or year prior to the measurement year.</p>

Information Required	Comment/Standardized Answer																												
<p><b>Measure Benchmarks:</b> The best performance or range of performance for the measure. How have these benchmarks been used?</p>	<p style="text-align: center;"><b>USABILITY</b></p> <p><input checked="" type="checkbox"/> Benchmark data attached  <input type="checkbox"/> There are no benchmark data</p> <p>This field-test, based on data from three health plans representing members from commercial, Medicaid and Medicare products, indicates there is significant room for improvement in the documentation of BMI in medical records. It also indicates that plans with the ability to capture these data via EMR could realize much higher rates of documentation when the EMR calculates BMI for the physician and stores it in a visit driven database that would allow trending over time. The field-test helped the NCQA staff and Obesity MAP determine that the measure would be most feasible if it requires an outpatient visit in the measurement year or year prior to the measurement year, and BMI documentation at any time during that period. There are no concerns about plan ability to report based on the size of the eligible population. This measure is based on the plan's adult membership 18–74 years of age, with at least one outpatient visit in the measurement year or year prior to the measurement year. When requiring an office visit in the measurement year or the year prior, the field-test indicates that 86% of the plan's adult population will meet the visit criteria and thus be included in the eligible population.</p> <p><b>Number and Percentage of Eligible Population with Office Visits</b></p> <table border="1" data-bbox="611 686 1575 919"> <thead> <tr> <th></th> <th>A</th> <th>B</th> <th>C</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Eligible population with at least 1 visit in 2005 or 2006 (N%)</td> <td>8,245</td> <td>175,447</td> <td>284,183</td> <td>467,875</td> </tr> <tr> <td>86.1%</td> <td>89.2%</td> <td>84.3%</td> <td>86.1%</td> </tr> <tr> <td></td> <td><b>Commercial</b></td> <td><b>Medicaid</b></td> <td><b>Medicare</b></td> <td></td> </tr> <tr> <td rowspan="2">Eligible population with at least 1 visit in 2005 or 2006 (N%)</td> <td>429,561</td> <td>2,897</td> <td>35,417</td> <td></td> </tr> <tr> <td>85.5%</td> <td>84.4%</td> <td>94.5%</td> <td></td> </tr> </tbody> </table> <p>What the field-test was not able to determine is how plans will perform using solely administrative data. There is a set of ICD-9-CM V-codes that indicate that BMI was assessed; these codes can be included on claims for plan capture, but none of the plans reported using the codes for their eligible population.</p> <p>The following table shows the number of members with BMI documented in addition to an office visit, the number of members with a visit each year or in either year, and the percentage of members with a BMI documented and office visit. Based on this information, a total of 30.6% of members had an office visit and their BMI documented in either 2005 or 2006. This rate varies between plans, from a low of 10% of members to a high of 93.3% of members. The plan that indicated 93.3% of members had BMI documented in 2005 or 2006 is the plan that utilized 100% EMR for reporting of results.</p>		A	B	C	Total	Eligible population with at least 1 visit in 2005 or 2006 (N%)	8,245	175,447	284,183	467,875	86.1%	89.2%	84.3%	86.1%		<b>Commercial</b>	<b>Medicaid</b>	<b>Medicare</b>		Eligible population with at least 1 visit in 2005 or 2006 (N%)	429,561	2,897	35,417		85.5%	84.4%	94.5%	
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Information Required	Comment/Standardized Answer				
<b>USABILITY</b>					
	Prevalence of BMI Documentation				
		A	B	C	Total
	BMI documented (n)	98	24	10	132
	Office visit in 2005 or 2006 (n)	105	133	93	431
	Percentage with BMI documented	93.3%	10.3%	10.8%	30.6%
		Commercial	Medicaid	Medicare	
	BMI documented (n)	80	34	18	
	Office visit in 2005 or 2006 (n)	308	37	86	
Percentage with BMI documented	25.9%	91.9%	20.9%		
<b>QUALITY OF SUPPORTING EVIDENCE</b>					
<p><b>Quality of Evidence:</b> To further improve and bring more transparency to the NQF process, all measure developers are required to grade the level of evidence submitted with measures. Developers are requested to use the United States Preventive Services Task Force (USPSTF) rating system on all evidence submitted:</p> <p>The USPSTF grades the quality of the overall evidence for a service on a three-point scale (Good, Fair, Poor).</p> <ul style="list-style-type: none"> <li>• <b>Good.</b> Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.</li> <li>• <b>Fair.</b> Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.</li> <li>• <b>Poor.</b> Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.</li> </ul> <p>More information on USPSTF and its rating system can be accessed at <a href="http://www.ahrq.gov/clinic/3rduspstf/ratings.htm">http://www.ahrq.gov/clinic/3rduspstf/ratings.htm</a>.</p>	<p>In general, the overall quality of evidence for this specific measure is Fair. There are a number of clinical guidelines stating that BMI assessment is the first step in treating overweight and obesity; however, the impact of this assessment has not been tested to see how it will directly impact the prevalence and severity of the condition.</p>				