

PRESENTED BY HIGHMARK RISK ADJUSTMENT ACCURACY MANAGEMENT

Morbid Obesity



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Agenda

1. Overview of the condition
 2. Coding & documentation considerations
 3. Documentation example
 4. Additional resources
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Morbid Obesity

Patients may be considered morbidly obese if:
They are currently **100 pounds or more above ideal body weight**

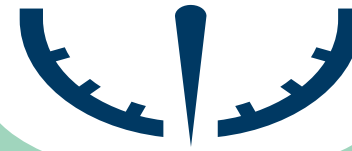
OR

Currently has a **BMI of 40 or greater**

OR

Currently has a **BMI of 35 or greater with one or more captured co-morbid conditions**
(e.g., hypertension, diabetes, GERD, sleep apnea, arthritis, heart disease high cholesterol)

Refer to the current version of the ICD-10-CM Official Guidelines for Coding and Reporting, the ICD-10-CM Index to Diseases and Injuries, and the Tabular List of Diseases for a list of all ICD-10-CM codes and coding instructions.



The weight diagnosis must be documented by a clinician.

Morbid (severe) obesity due to excess calories
E66.01

Morbid (severe) obesity with alveolar hypoventilation
E66.2

Class 3 Obesity (BMI: 40 or greater)
E66.813

Class 2 Obesity (BMI: 35 to less than 40)
E66.812

Class 1 Obesity (BMI: 30 to less than 35)
E66.811

Body Mass Index (BMI)

The body mass index (BMI) is used as a screening tool for clinicians. While a non-physician can document the BMI, it's only reported secondarily, requiring a primary diagnosis (e.g., morbid obesity,) from a clinician. Coding for BMI necessitates a related clinician-documented weight diagnosis. Therefore, a BMI code alone is insufficient.



1st

Diagnosis Code

Clinician documented weight diagnosis



2nd

Diagnosis Code

Recorded BMI (Calculation of patient's current height & weight)

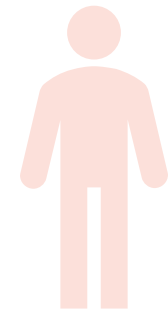
Z68.41 BMI 40.0-44.9 adult

Z68.42 BMI 45.0-49.9 adult

Z68.43 BMI 50-59.9 adult

Z68.44 BMI 60.0-69.9 adult

Z68.45 BMI 70 or greater, adult



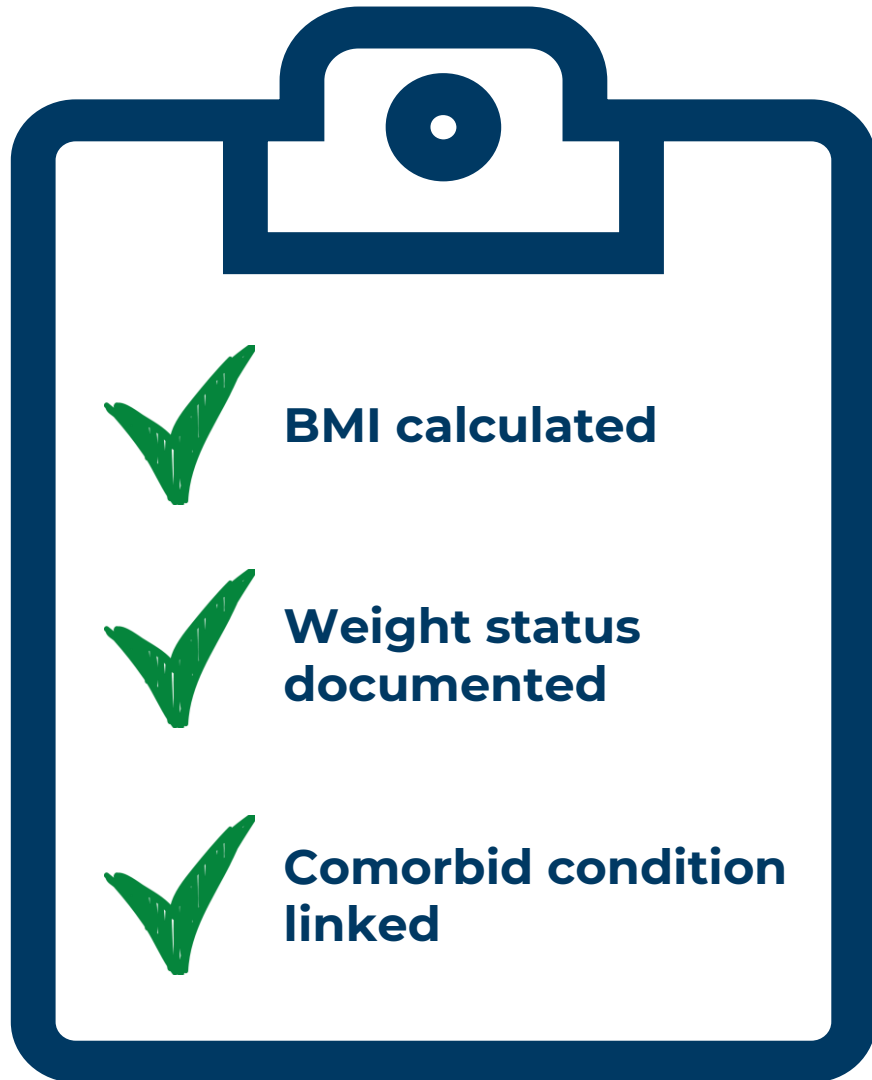
**A complete picture
of the patient's
health**

Morbid Obesity

Key tips to assist with accurately and completely capturing morbid obesity:

- 1. Document the patient's height, weight, and BMI.**
 - BMI should be calculated at minimum annually.
- 2. Note any physical findings** from the exam.
 - General statements regarding appearance such as “appears obese” or findings of “obese abdomen” will not support a weight status.
- 3. Document the weight diagnosis** in the assessment.
 - Severe obesity is synonymous with morbid obesity.
 - Obesity severity is determined by current BMI.
 - Include the cause, if known.
 - Include any associated comorbid conditions such as hypertension, diabetes, sleep apnea, etc.
- 4. Assign ICD-10 codes for both the weight status and the BMI.**
 - Coders cannot report morbid obesity from a BMI value alone. Clinicians must document the patient's weight diagnosis.
 - BMI code cannot be reported alone (secondary code only)
- 5. Note a detailed treatment** plan.
 - Incorporate discussions and advice given to the patient. Include orders for additional lab work, referrals, procedures, therapy, prescribed medications (including dosages), and patient education.
 - **GLP-1 Use:** May require long term use to prevent weight regain. The obesity class/severity should align with the current BMI at the time of visit even if the patient continues to use a GLP-1.

Morbid Obesity Example



Chief Complaint:

45-year-old male **with severe obstructive sleep apnea and associated morbid obesity.**

Physical Exam:

Vitals: **BMI 38.2**

General Appearance: **Patient is morbidly obese.**

Assessment & Plan:

Morbid (severe) obesity due to excess calories (E66.01)

BMI 38.0-38.9, adult (Z68.38)

Discussed dietary changes and reduced caloric intake. Will schedule consult appointment with dietician.

After calculating the patient's BMI, the clinician determined the associated weight diagnosis and linked complication to comorbid condition. Both the BMI and morbid obesity diagnoses were documented in the assessment with corresponding ICD-10 codes, along with a documented treatment plan.

Additional Resources

Documentation Best Practice Checklist



Annually assess all chronic conditions and document a plan for each one



Link medications to help establish ongoing treatment especially if the medication is used to treat multiple conditions.



Use the term “History of” before a condition if it no longer exists or has resolved



Validate patient reported findings



Code and document all coexisting conditions that require or affect patient care, treatment or management



Avoid using uncertain terms when a diagnosis has been confirmed for a patient



Choose the highest level of specificity when selecting an ICD-10 code



Keep problem list up to date by removing acute and one-time conditions

Highmark Provider Resource Center

KNOWLEDGE COLLEGE

15-minute on-demand courses on risk adjustment coding and documentation to help clinicians comply with CMS standards and ICD-10-CM guidelines

1. Log into Availity.
2. Navigate to the Provider Resource Center.
3. Locate “Resources and Education” in the menu bar and navigate to “Clinical Quality & Education”.
4. Select “Coding Education/HCC University”.

RISK ADJUSTMENT OVERVIEW

Review the foundations of what risk adjustment is, hierarchical condition categories, common errors, best practices and impacts to patient care



CODING & DOCUMENTATION CARDS

Reference cards to assist with documentation and coding according to CMS documentation standards and ICD-10-CM coding requirements



Have questions about risk adjustment?

**Want to share feedback or suggest topics
for future presentations?**

Email:

RiskAdjustmentCoding@Highmark.com