

NQF 0024: Weight Assessment Counseling for Children and Adolescents

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.

NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR). The first two sections may be distributed as stand-alone references.

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and exceptions or exclusions.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and exceptions or exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, ICD, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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NQF 0024: Weight Assessment Counseling for Children and Adolescents

The percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Alternate core measure
Related to other measures?	<ul style="list-style-type: none"> Some of the information entered for this clinical quality measure is related to the following measure: <ul style="list-style-type: none"> Adult Weight Screening and Follow-Up (NQF 0421)
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Encounter codes¹
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> Diagnosis of or encounter for pregnancy¹
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> BMI (need height and weight)¹ Body Mass Index percentile¹ Communication to patient: counseling for nutrition¹ Communication to patient: counseling for physical activity¹

Note: This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, visit: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> Ensures only patients who are 2-17 years old at the start of the measurement period are included in the denominator 	<ul style="list-style-type: none"> Date of birth 	
2. Record the date and type of visit	<ul style="list-style-type: none"> Ensures appropriate visits are captured in the denominator 	<ul style="list-style-type: none"> Date of visit Code for a PCP or Ob/Gyn outpatient encounter² 	
3. Document if patient is pregnant	<ul style="list-style-type: none"> Ensures patients who are pregnant are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Document active diagnosis of pregnancy³ 	

¹ This data element(s) must be documented during the measurement period

² See Technical Supplement for denominator inclusion details (encounter types): [TS-2](#)

³ See Technical Supplement for exclusion or exception details (pregnancy): [TS-3](#)

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
4. Ascertain weight and height	<ul style="list-style-type: none"> Allows for the calculation of BMI, which is needed for Numerator 1 	<ul style="list-style-type: none"> Weight in kilograms (kg) or pounds (lb) Height in meters (m) or inches (in) 	
5. Calculate patient's BMI	<ul style="list-style-type: none"> Allows BMI to be assessed as a percentile, which is needed for Numerator 1 	<ul style="list-style-type: none"> Body Mass Index (BMI)⁴ 	
6. Assess patient's BMI	<ul style="list-style-type: none"> Captures the weight assessment activity in your EHR for Numerator 1 	<ul style="list-style-type: none"> Document physical exam finding: BMI percentile⁵ 	
7. Counsel patient for nutrition	<ul style="list-style-type: none"> Documentation captures nutrition counseling activity for Numerator 2 	<ul style="list-style-type: none"> Document counseling for nutrition⁶ 	
8. Counsel patient for physical activity	<ul style="list-style-type: none"> Documentation captures physical activity counseling activity for Numerator 3 	<ul style="list-style-type: none"> Document counseling for physical activity⁷ 	

⁴ If manual calculation of body mass index is needed, use one of the formulae below:

[English BMI Formula] BMI = [Weight in Pounds / (Height in inches x Height in inches)] x 703; or

[Metric BMI Formula] BMI = [Weight in Kilograms / (Height in Meters x Height in Meters)]

⁵ See Technical Supplement for denominator inclusion details (BMI percentile): [TS-3](#)

⁶ See Technical Supplement for denominator inclusion details (counseling for nutrition): [TS-4](#)

⁷ See Technical Supplement for numerator inclusion details (counseling for physical activity): [TS-5](#)

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure denominator and numerator.

DENOMINATOR INCLUSION CRITERIA

What constitutes an outpatient visit with a PCP or OB/GYN? (CPT Codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.
- Observation care discharge day management (for all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status.")
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an examination, and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, a problem focused examination, medical decision making.
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient.
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient.
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (distinct from evaluation and management services)
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (distinct from evaluation and management services);
- Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by the treating physician or other than treating physician that includes: A medical history and examination commensurate with the patient's condition, formulation of a diagnosis, assessment of capabilities and stability, calculation of impairment, development of future medical treatment plan, and completion of necessary documentation/certificates and report.

What constitutes an outpatient visit with a PCP or OB/GYN? (ICD-9 Codes)

• Postpartum care and examination	V24
• Encounter for contraceptive management	V25
• Procreative management	V26
• Outcome of delivery	V27
• Encounter for antenatal screening	V28
• Presence of contraceptive device	V45.5
• Multiparity	V61.5
• Illegitimacy or illegitimate pregnancy	V61.6
• Other unwanted pregnancy	V61.7
• High risk sexual behavior	V69.2

What constitutes an outpatient visit with a PCP or OB/GYN? (ICD-9 Codes)

• Gynecological examination	V72.3
• Pregnancy Examination or test	V72.4
• Routine general examination at a health care facility	V70.0
• Other medical examination for administrative purposes	V70.3
• Health examination of defined subpopulations	V70.5
• Health examination in population surveys	V70.6
• Other specified general medical examinations	V70.8
• Unspecified general medical examination	V70.9

What counts as an outpatient visits with a PCP or OB/GYN? (ICD-10 Codes)

• Routine child health examination	Z00.1
• <i>Unknown description</i>	Z00.10
• Newborn Health Examination	Z00.11
• Examination for period of rapid growth in childhood	Z00.2
• Examination for adolescent development state	Z00.3
• Examination for period of delayed growth in childhood	Z00.7-Z00.71
• Other general examinations	Z00.8

EXCLUSION OR EXCEPTION CRITERIA

What constitutes a pregnancy encounter? (ICD-9 Codes)

• Encounter for assisted reproductive fertility procedure cycle	V26.81
• Encounter for antenatal screening for mother	V28
• Encounter for routine screening of for malformation using ultrasonics	V28.3
• Encounter for fetal anatomic survey	V28.81
• Encounter for screening for risk of pre-term labor	V28.82
• Pregnancy examination or test	V72.4
• Pregnancy examination or test, pregnancy unconfirmed	V72.40
• Pregnancy examination or test, negative result	V72.41
• Pregnancy examination or test, positive result	V72.42

What counts as a pregnancy diagnosis?⁸ (ICD-9 Codes)

• Ectopic and molar pregnancy	630-633
• Other pregnancy with abortive outcome	634-639
• Complications mainly related to pregnancy	640-649
• Normal delivery, and other indications for care in pregnancy, labor, and delivery	650-659
• Complications occurring mainly in the course of labor and delivery	660-669
• Complications of Puerperium	670-677
• Other maternal and fetal complications	678-679
• Normal Pregnancy	V22-V22.2

⁸ SNO-MED-CT codes may also be used to document a pregnancy diagnosis.

What counts as a pregnancy diagnosis?⁸ (ICD-9 Codes)

- | | |
|---|-----------|
| • Supervision of high risk pregnancy | V23-V23.9 |
| • Encounter for antenatal screening of mother | V28-V28.9 |

NUMERATOR 1 INCLUSION CRITERIA

What constitutes BMI percentile finding? (ICD-9-CM codes)

- | | |
|--|--------|
| • Body Mass Index, pediatric | V85.5 |
| • Body Mass Index, pediatric, less than 5th percentile for age | V85.51 |
| • Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age | V85.52 |
| • Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age | V85.53 |
| • Body Mass Index, pediatric, greater than or equal to 95th percentile for age | V85.54 |

What constitutes BMI percentile finding? (ICD-10-CM codes)

- Body Mass Index (BMI)
- Body Mass Index (BMI) 19 or less, adult
- Body Mass Index (BMI) pediatric
- Body Mass Index (BMI) pediatric, less than 5th percentile for age
- Body Mass Index (BMI) pediatric, 5th percentile to less than 85th percentile for age
- Body Mass Index (BMI) pediatric, 85th percentile to less than 95th percentile for age
- Body Mass Index (BMI) pediatric, greater than or equal to 95th percentile for age

What constitutes BMI percentile finding? (SNOMED-CT codes)

- Body mass index normal K/M2 (finding)
- Body mass index high K/M2 (finding)
- Body mass index low K/M2 (finding)
- Body mass index 25-29 - overweight (finding)
- Body mass index 30+ - obesity (finding)
- Normal body mass index (finding)
- Body mass index 40+ - severely obese (finding)
- Body mass index 20-24 - normal (finding)
- Body mass index less than 16.5 (finding)
- Increased body mass index (finding)
- Body mass index (finding)
- Decreased body mass index (finding)

NUMERATOR 2 INCLUSION CRITERIA

What constitutes counseling for nutrition? (ICD-9-CM codes)

- | | |
|---|-------|
| • Dietary surveillance and counseling (in): NOS, colitis, diabetes mellitus, food allergies or intolerance, gastritis, hypercholesterolemia, hypoglycemia, obesity. Use additional code to identify Body Mass Index (BMI), if known | V65.3 |
|---|-------|

What constitutes counseling for nutrition? (ICD-10-CM codes)

- Encounter for newborn, infant and child health examinations
- Newborn health examination
- Encounter for examination for period of rapid growth in childhood
- Encounter for examination for adolescent development state
- Encounter for examination for period of delayed growth in childhood
- Encounter for examination for period of delayed growth in childhood, without abnormal findings
- Encounter for examination for period of delayed growth in childhood, with abnormal findings
- Encounter for other general examination
- Lack of physical exercise
- Inappropriate diet and eating habits

What constitutes counseling for nutrition? (CPT codes)

- Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

What constitutes counseling for nutrition? (HCPCS codes)

- Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
- Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
- Weight management classes, non-physician provider, per session
- Nutrition classes, non-physician provider, per session
- Nutritional counseling, dietitian visit

NUMERATOR 3 INCLUSION CRITERIA

What constitutes counseling for physical activity? (ICD-9-CM codes)

- Exercise counseling V65.41

What constitutes counseling for physical activity? (ICD-10-CM codes)

- Dietary counseling and surveillance

What constitutes counseling for physical activity? (HCPCS codes)

- Exercise classes, non-physician provider, per session

TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

NQF0024	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x			x	x		x	x			x
Denominator ²	x					x					
Exceptions or Exclusions ³				x			x	x			x

- Codes with an asterisk (*) are required from certified EHRs
- ¹ To identify the numerator in this CQM, the following standard codes are required: one "physical exam" code found in the ICD-9, ICD-10, SNOMED or Grouping AND a "communication" code found in CPT, HCPCS, ICD-9, or ICD-10.
- ² To identify the denominator in this CQM, the following standard codes are required: an "individual characteristic" code from HL7, and an "encounter" code from CPT, ICD-9, ICD-10, or Grouping.
- ³ To identify the exceptions or exclusions in this CQM, the following standard codes are required: an "encounter" code in ICD-9 OR a "diagnosis/condition/problem" code from ICD-9, ICD-10, SNOMED or Grouping.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)

Abbreviation	Long Name	Definition/Description
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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