CCBHC Demonstration Program
Frequently Asked Questions about BMI Measures

1. **How is the BMI-SF measure calculated?**
    a. As highlighted on pages 46-47 of the Technical Specifications Manual Volume 1 document (posted on OHA's CCBHC website):
        i. Measurement Period: The measurement year and the previous six months
        ii. Data Source: Medical Records
        iii. Denominator: all clients aged 18 and older (***as of the date of service***) who have been seen at the CCBHC during the measurement year. The following CPT/HCPCS codes are considered eligible patient encounters: 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, H0004, H0039
            1. The client's age at the date of service must also be reported
            2. A client can be excluded from the denominator for certain reasons. These reasons are listed on page 48 of the Technical Specifications Manual Volume 1.
        iv. Numerator – The number of clients in the denominator with a documented BMI during the encounter or during the previous six months AND, when the BMI is outside of normal parameters, a follow-up plan is documented (either during the encounter or during the previous six months). The documented follow-up plan MUST be based on the most recent documented BMI.
            1. **The source of all documentation is the medical record**
            2. Below are the coding possibilities related to the numerator:

CPT/HCPCS Code	Description	Count for Numerator
G8420	BMI is documented within normal parameters and no follow-up plan is required	Yes
G8417	BMI is documented above normal parameters and a follow-up plan is documented	Yes
G8418	BMI is documented below normal parameters and a follow-up plan is documented	Yes
G8421	BMI is not documented and no reason is given	No
G8419	BMI is documented outside normal parameters, but no follow-up plan is documented and no reason is given	No

            3. If a clinic is using G-codes to identify members for the numerator, one of the first three codes from the table above (**G8420, G8417, or G8418**) must be listed in the medical record.
            4. SAMHSA's preference is that clinics use the G-codes to track compliance, or work toward the use of G-codes. Failing that, the clinic

should make sure that this information is in the EHR and can be captured so that the process can be automated.

b. For information on calculating the rate, please refer to pages 39-41 of the Technical Specifications Manual Volume 2 document (posted on OHA's CCBHC website).

2. What are the qualifying base codes for the BMI-SF measure?

a. These codes are referenced on pages 1-2 of the file "2016_PQRS_Measure_128_11_17_2015.pdf". A link to this file can be found by going to the Technical Specifications Manual Volume 1 document (posted on OHA's CCBHC website), and going to page 44.

3. If a BMI measure is documented after the last CCBHC encounter of the measurement year, can it still count toward the numerator?

a. No. the BMI must be recorded within the six months prior to the last CCBHC encounter of the measurement year. Any BMI recorded after the last CCBHC encounter would not count.

4. Does a PCP or OB/GYN need to obtain the measurement, or can any staff member at the CCBHC obtain it?

a. **Guidance from SAMHSA (Aug 2017)**: To be compatible with the source measure, the BHC measure states that the assessment should be completed by a PCP or OB/GYN. We realize this will make it difficult in many cases to obtain data and assure that the BMI screening occurs. For this reason and in the context of the CCBHC demonstration, the BMI screening may be conducted by medical personnel at either the CCBHC or a DCO without regard to whether they are a PCP or OB/GYN for the consumer, as long as they are operating within the scope of practice for their licensure. Because this is a deviation from the measure Technical Specification, however, it should be so indicated in the section of the data reporting template where adherence or nonadherence to the Technical Specification is reported. We also refer you to the questions and clarifications that may be found at https://www.samhsa.gov/sites/default/files/questions-clarifications-about-specific-qms.pdf.

b. This applies to both the BMI-SF and WCC-BH measures

5. Some measures (BMI-SF, ASC, DEP) utilize HCPCS G-codes, which are not reimbursable for behavioral health providers in Oregon. How do we report on these measures?

a. It is requested that clinics add the G-codes for these measures into their EHR for reporting purposes and use the billing codes they would normally use for reimbursement when submitting claims.

b. SAMHSA's preference is that the G-codes are used, and the process (of capturing this information) is automated. Failing that, you could use some other form of documentation, but you should try to make sure that it is in the EHR and can be captured to allow you to automate the process. SAMHSA states that clinics should work towards use of the G-codes

6. **Clarifications from SAMHSA to CCBHCs on BMI-SF**
    a. **Coming at the quality measures from a person-centered perspective, can the state design or define the population on whom we will collect measures? For example, collecting BMI from some individuals may have the unintended consequence of creating a barrier to getting the services that those people are seeking.**
        i. There is no provision for selective application of the measures beyond the criteria for measurement in the Technical Specifications Manual. We understand that some behavioral health clients might not want to receive certain physical health services at the BHC and that trying to provide these services could hamper their acceptance of the behavioral health services they need. It also is possible that some of the hesitation may be on the part of providers who have not tried to collect this information. However, these screenings would be conducted by a nurse or medical assistant rather than by a therapist, which will allow for boundaries with regard to these services. There also are some measures that have exclusions or exceptions that excuse inclusion in the measures. Looking at the adult BMI measure in particular, at least two of the following documented exclusions might apply:
            1. Consumer is receiving palliative care
            2. Consumer is pregnant
            3. Consumer refuses BMI measurement (i.e., refuses height and/or weight)
            4. Any other reason documented in the medical record by the provider as to why a BMI measurement was not appropriate
            5. Consumer is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the consumer's health status
    b. **Can the measures be adapted by states? For instance, the BMI measure that was put out by SAMHSA states that a person with a BMI of 25 or greater requires a substantial amount of follow-up. However, in our state, that level of follow-up is required only if the person has a BMI of 30 or greater.**
        i. Most of the measures were not created for the compilation of BHC quality measures; rather, most were adapted from current measures and cannot be changed. The requirements for the measure BMI should remain the same for each state.
    c. **For the adult BMI measure, is the expectation for the BHC to generate the BMI or obtain it from other practitioners? If the latter, how?**
        i. BMI can be generated at the BHC, which is the way that you can assure you actually get the information. Also, if you are working with a DCO as a CCBHC and the DCO is doing physical health screening, it should be able to provide you with those data. Part of the requirement for being a DCO is that they will provide you with the data that are needed to calculate these measures. If you have to obtain this information from a non-DCO provider (e.g., a PCP that is not associated with the BHC or DCO), you will need a care coordination agreement with the pertinent PCP or whoever else may be doing the screening. Because obtaining

this required agreement with a non-DCO provider is more difficult, your best options probably involve doing it yourself or having a DCO that will do it.

d. For the adult BMI measure, if consumers choose to keep their own PCPs who are not within the BHC, will we need to contact those PCPs for the consumers' BMI information?

i. Yes, although BHCs also have the option of conducting the BMI screening and follow-up planning internally

e. For the adult BMI measure, if the documentation is from another provider and not the BHC, does the patient record at the BHC have to include a copy of the screening? Is the BHC required to address follow-up plans or can this be done by the original screening provider?

i. The original screening provider can develop and perform the follow-up plan. This measure is fairly open in terms of who can do what, but the BHC does need to have access to the data indicating that the follow-up happened. There has to be some mechanism for the BHC to obtain the data. Ideally, the mechanism would be an electronic data exchange. If not, it would need to be in the paper record.

f. For the adult BMI measure (BMI-SF), the Technical Specification states that self-reporting of height and weight is not permitted. What if it is obtained by the PCP?

i. If the PCP has recorded height and weight, it is most likely going to be an actual measurement.

g. For the adult BMI measure, can we build a clinical decision support rule in the EHR to satisfy the documentation requirement for the follow-up plan?

i. This may depend on the EHR and the BHC's ability to adjust it. But yes, it would be optimal to build screenings or guidance into the EHR for decision support if that is possible.

h. For the adult BMI measure, is it sufficient to pull data documenting the follow-up plan by simply clicking on a box in the EHR stating that follow-up was initiated or the other items billeted on page 45 of the Technical Specifications in the Follow-Up box? Or will a chart audit or review of documentation be required to demonstrate the measure?

i. Success on the measure requires documented BMI screening and, if the BMI is outside normal limits, a documented follow-up plan. It seems the question is asking about the documentation of the follow-up plan in particular. This measure uses medical records, and BHCs can rely on paper (chart review) or EHR to document this. If the BHC can format the EHR so that the clinician doing the screening and arranging a follow-up plan can indicate that in the EHR, that would no doubt be easiest. Use of the G codes in that way would be most desirable.

i. For the adult BMI measure, if a consumer has multiple services during the MY, are we only collecting data from the most recent or earliest service during the MY?

i. BHCs are not required to measure BMI every time there is a service. The consumers could have multiple services that have absolutely nothing to do with BMI, or they could have just one BMI screening during the year. If by chance

they had their BMI measured multiple times, the BHC should only count the last occurrence.

j. **For the adult BMI measure, if a consumer's BMI was taken and a plan to address the issue was documented, do we have to have another plan if that consumer is seen again within a week or so, even though we already have one documented and it is being implemented?**
    i. No, you do not. The measure is designed to ensure the BMI screening is done at least once a year.

k. **For the adult BMI measure, the measure relates to a BMI during the encounter or within 6 months prior. This appears to be encounter-based rather than a member-based measure. If a member has multiple encounters during the MY, are all encounters evaluated?**
    i. Only one BMI screening is counted, and that is the most recent. This is a consumer-based rather than an encounter-based measure. The denominator includes consumers of the pertinent age who were seen at the BHC at least once in the MY and who have at least one of the eligible encounters. This measure, which looks at data for the MY only to identify the eligible population, is designed to capture those seen during the MY. The numerator looks at the subset of the eligible population who have a documented BMI and, if needed, a follow-up plan. The data used to see if the BMI and follow-up were documented reflect encounters during the MY, but the BHC can look back 6 months from the encounter to see if BMI was documented earlier. (This may involve looking at data in the prior year if the consumer's encounter is early in the MY.) This gives the reporter a 6-month grace period in which to have performed the screening.

l. **For the measure of adult BMI (BMI-SF), if there were a series of eligible encounters with normal BMI, then there was a BMI that was abnormal but no follow-up plan was documented until the next eligible encounter, would that consumer be counted in the numerator?**
    i. No, the follow-up plan must be documented during the same encounter as the BMI screening or have been documented at some point in the previous six months.

m. **For the adult BMI measure, our state does not have a billable code for medical assistants to take BMI vitals in behavioral health settings. Would medical assistants be allowed to take vital signs for BMIs?**
    i. There is nothing in this measure that specifies what kind of provider it has to be beyond the required use of encounter codes to establish the eligible population visits for the denominator. CCBHCs must follow the state's licensing, credentialing, and scope of practice regulations.

7. **For the BMI, Tobacco, and Alcohol measures (BMI-SF, WCC-BH, TSC, and ASC), if the clinic collects data more than once for a client, does the clinic report data from each screening, or only the most recent one?**
    a. **Guidance from SAMHSA (Aug 2017):**

i. For BMI-SF, you only count each client once in the denominator for the measurement period and, for the numerator (was the client screened, and was there a plan if needed?), if more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met.
ii. For WCC-BH, the specification does not indicate. Please use the same approach as for BMI-SF.
iii. For TSC and ASC, it is once per measurement year. If they are screened multiple times per year, use the most recent screening.

8. How is the WCC-BH measure calculated?

a. As highlighted on pages 52-54 of the Technical Specifications Manual Volume 1 document (posted on OHA's CCBHC website):
   i. Measurement Period: The measurement year and the previous six months
   ii. Data Source: Medical records (administrative) or chart review (hybrid)
   iii. Denominator: all clients aged 3-17 (***as of the end of the measurement year***) who have been seen at the CCBHC during the measurement year. The following CPT/HCPCS codes are considered eligible patient encounters: 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, H0004, H0039
      1. The client's age at the date of service must also be reported
      2. The sample will be stratified into two age groups
         a. 3-11 years of age
         b. 12-17 years of age
      3. Exclusions:
         a. Clients who have a diagnosis of pregnancy during the measurement year
         b. Clients who have more than one gap in coverage during the measurement year, or have one gap in coverage exceeding 45 days

iv. Numerator – The number of clients in the denominator with a documented ***BMI percentile*** during the measurement year

1. If using administrative data to calculate the numerator, below are the qualifying base codes related to the numerator:

Code System	**Code**
ICD-10	Z68.51
ICD-10	Z68.52
ICD-10	Z68.53
ICD-10	Z68.54
ICD-9	V85.51
ICD-9	V85.52
ICD-9	V85.53
ICD-9	V85.54

2. If using medical record review to calculate the numerator
    a. Note this in the Additional Notes section on the template
    b. Note that documentation must include height, weight, and BMI percentile during the measurement year ***from the same data*** source
    c. Records that include notation of BMI value only, or height and weight only do not count as numerator compliant
    d. Either BMI percentile or BMI percentile plotted on an age-growth chart meets criteria

9. **What are the qualifying base codes for the WCC-BH measure?**
    a. The qualifying base codes for this measure are listed in the NCQA HEDIS 2016 Value Set. Per the HEDIS specifications for the ABA measurement, these are the base codes:

Code System	Code
ICD-10	Z68.51
ICD-10	Z68.52
ICD-10	Z68.53
ICD-10	Z68.54
ICD-9	V85.51
ICD-9	V85.52
ICD-9	V85.53
ICD-9	V85.54

10. **Does a PCP or OB/GYN need to obtain the measurement, or can any staff member at the CCBHC obtain it?**
    a. **Guidance from SAMHSA (Aug 2017)**: To be compatible with the source measure, the BHC measure states that the assessment should be completed by a PCP or OB/GYN. We realize this will make it difficult in many cases to obtain data and assure that the BMI screening occurs. For this reason and in the context of the CCBHC demonstration, the BMI screening may be conducted by medical personnel at either the CCBHC or a DCO without regard to whether they are a PCP or OB/GYN for the consumer, as long as they are operating within the scope of practice for their licensure. Because this is a deviation from the measure Technical Specification, however, it should be so indicated in the section of the data reporting template where adherence or nonadherence to the Technical Specification is reported. We also refer you to the questions and clarifications that may be found at https://www.samhsa.gov/sites/default/files/questions-clarifications-about-specific-qms.pdf.
    b. This applies to both the BMI-SF and WCC-BH measures

11. **For measures that have hybrid data sources (WCC-BH and CDF-BH), are clinics required to use the sampling methodology if they are more easily able to report on all consumers?**
    a. No, if clinics can more easily track all consumers instead of picking a sample, it is preferred that clinics report on all consumers. Please make a note in the reporting template on these measures whether you are using your entire consumer population or a sample.

12. **For the BMI, Tobacco, and Alcohol measures (BMI-SF, WCC-BH, TSC, and ASC), if the clinic collects data more than once for a client, does the clinic report data from each screening, or only the most recent one?**
    a. **Guidance from SAMHSA (Aug 2017):**
        i. For BMI-SF, you only count each client once in the denominator for the measurement period and, for the numerator (was the client screened, and was there a plan if needed?), if more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met.
        ii. For WCC-BH, the specification does not indicate. Please use the same approach as for BMI-SF.
        iii. For TSC and ASC, it is once per measurement year. If they are screened multiple times per year, use the most recent screening.