Coding and Documentation Tips: Morbid Obesity (MO) and Body Mass Index (BMI)

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ICD-10-CM includes General Guidelines for Documentation for BMI.[1]

The Tabular Lists (E66), instruct to "Use additional code to identify BMI, *if known*" (Z68.-). Official coding guidelines indicate that someone who cannot make a diagnosis (e.g., nurse, medical assistant, or dietician) **may document the BMI**. However, the guidelines state that BMI should only be reported as a secondary diagnosis; therefore, to report BMI, a related primary diagnosis (such as overweight, obesity) **should be** documented by the patient's provider.

Codes for overweight, obesity or morbid obesity are assigned based on the provider's documentation of these conditions. Therefore, if morbid obesity is documented, assign code E66.01, Morbid (severe) obesity due to excess calories. While the BMI is used as a screening tool for patients who are overweight or obese, there is no coding rule that defines what BMI values correspond to obesity or morbid obesity, since the conditions are coded only when diagnosed and documented by the provider or another physician involved in the patient's care.

As noted in the Official Guidelines for Coding and Reporting, Section I.A.19, "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis." Please refer to Coding Clinic, Fourth Quarter 2016, pages 147-149, for additional information regarding this guideline.

Documentation from physicians other than the attending physician (i.e., consultants, residents, anesthesiologists, etc.) is acceptable, as long as there is no conflicting information from the attending physician.

To assign a code for BMI, an associated clinical condition must be documented by the provider (i.e., morbid obesity, overweight, or obesity). It is not appropriate to assign a code for the BMI without an associated diagnosis. The advice further clarifies that obesity and morbid obesity are always clinically significant and reportable conditions that should be reported when documented by the provider.

Furthermore, individuals who are overweight, obese, or morbidly obese are at increased risk for certain medical conditions compared to people of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider.

ICD-10-CM Codes	Code Descriptions
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug induced obesity. Use additional ode for adverse effect, if applicable, to identify drug (T36-T50 with 5th or 6th character 5)
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified

[1] 2023 Official ICD-10-CM Coding Guidelines, Section 1.B.14

Morbid Obesity

If a provider documents "Morbid Obesity" within an encounter, **E66.01 Morbid (severe) obesity due to excess calories** can be reported/coded. Guidelines state this is allowed/acceptable.

If a provider only documents, "overweight" or "obese" those are codable to **E66.3** or **E66.9**, but Morbid Obesity cannot be reported if only those are documented.

The documentation of Morbid Obesity by the provider can be anywhere in the current visit document.

- History of Present Illness
- Review of Systems
- Physical Exam
- Assessment and Plan

If Morbid Obesity is only in the PMH (Past Medical History) or PL (Problem List), MO would not be reported. Because the PMH/PL tend to be pulled over from past encounters or are "old" data, there is no way to guarantee the diagnosis is current. In the case MO is in the PMH/PL, review the remainder of the note to find documentation of the diagnosis. If not able to locate and/or support, then the MO **would not be reported/coded**.

Body Mass Index (BMI)

For Risk Adjustment purposes, a BMI of 40+ needs to be documented. BMI can be noted in an encounter by non-providers (MA, dietician, nurse, etc.). But to be able to report/code the BMI **(Z68.4x – Body Mass Index (BMI)…)** the provider needs to document "obese", "overweight," "morbidly obese," etc. Without the supporting documentation by the provider, the BMI cannot be reported/coded.

- Even if there is documentation of an extremely high BMI, it is not up to the coder to assume Obesity, etc.

Examples (Morbid Obesity):

- Physical exam/General – **Morbidly obese** male, well nourished, mood good.
    - This simple documentation allows **E66.01 - Morbid (severe) obesity due to excess calories**, to be reported/coded.

Example (Body Mass Index):

- Vitals – BMI **50.1**; HPI – 56-year-old, **obese** female with history of diabetes mellitus, hypertension, cardiovascular attack, here for yearly visit.
    - In this instance, **Z68.43 – Body Mass Index (BMI) 50.0-59.9** would be reported/coded because the BMI is documented and is higher than 40 and the provider documented "obese".
    - If the BMI was not anywhere in the note, and the provider still noted the patient as "obese.":
        - **E66.9 – Obesity, unspecified** would be the code reported.

*Thus, when reviewing documentation in which the BMI is ≥40 but an associated condition has not been addressed, an educational note to the provider encouraging them to address overweight, obesity, or morbid/severe obesity is strongly encouraged. *