A patient’s body mass index (BMI) can have a profound effect on the complexity of care and the risks of complications, morbidity and mortality. In addition, BMI <19 or BMI ≥40 is classified as a comorbidity that can affect quality performance scores and reimbursement.

To qualify, the abnormal BMI must be documented specifically in the medical record by the physician or by a nutritionist. There must also be a clinical diagnosis or condition documented by the physician that corresponds to the abnormal BMI. Incorporating the BMI with vital signs on the history and physical (especially for electronic records) helps to meet this requirement.

A BMI ≥40 with the terms “morbid obesity,” “obesity” or “overweight” would qualify as a diagnosis. For BMI <19, a diagnosis of “underweight,” “nutritional risk” or “malnutrition” will do, particularly if a nutrition consult is requested.

In summary, it is very important to have abnormal BMI documented in the medical record as well as the clinical condition associated with it. The diagnosis of malnutrition and its severity is also important but requires consideration of multiple clinical variables. The ultimate diagnosis of malnutrition and its severity depends upon the physician’s clinical judgment based on a constellation of the above findings in each individual case. No particular finding is required or definitive. It’s interesting to note that coding rules consider “emaciation” to be severe malnutrition but not “cachexia,” even though most physicians use the terms interchangeably.

Richard Pinson, FACP, is a certified coding specialist and co-founder of HCQ Consulting (www.hcqconsulting.com) in Houston. This content is adapted with permission from HCQ Consulting.