Elder Maltreatment Screen and Follow-Up Plan

Coding Specifications

Codes required to document a visit occurred:

A CPT code or a G-code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT codes or G-codes

- 90801
- 90802
- 96116*
- 96150
- 97003
- 97802, 97803*, G0270*

**Note: When reporting CPT codes 96116, 97803, or G0270, the measure is to be reported each time the code is submitted.*

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- ***G8534:*** Documentation of an elder maltreatment screen and follow-up plan
- ***G8537:*** Elder maltreatment screen documented, follow-up plan not documented, patient not eligible
- ***G8535:*** No documentation of an elder maltreatment screen, patient not eligible (eg, not an initial visit[1] patient refuses to participate, patient is in an urgent or emergent situation and to delay treatment would jeopardize the patient's health status
- ***G8536:*** No documentation of an elder maltreatment screen, reason not specified
- ***G8538:*** Elder maltreatment screen documented, follow-up plan not documented, reason not specified

[1]Excluding CPT or HCPCS Codes 96116, 97803, G0270—the elder maltreatment screen and documented follow-up is required at every visit for these procedure codes.

These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

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