## 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 SAME CLAIM.

## **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<sup>1</sup> 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

<sup>1</sup>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.