Geriatric Care

Elder Maltreatment Screen and Follow-Up Plan

PQRI Data Collection Sheet

		/ /	☐ Male ☐ Female
Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	Gender
National Provider Identifier (NPI)		Date of Service	

Clinical Information

Billing Information

Step 1 Is patient eligible for this measure?

	Yes	No	Code Required on Claim Form
Patient is aged 65 years or older on date of encounter.	☐	☐	Verify date of birth on claim form.
There is a CPT Code or a G-code for this visit.	☐	☐	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
If **No** is checked for any of the above, STOP. Do not report a G-code.			

Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

Elder Maltreatment	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Screened[1] AND follow up plan[2] documented	☐	☐	G8534
Not screened for the following reason: • Documented reasons (ie, not an intial visit/intake interview[3], patient refuses to participate, patient is in an urgent or emergent situation and to delay treatment would jeopardize the patient's health status)	☐	☐	G8535
Screened, but no follow up plan documented for the following reason: • Documented reasons (ie, patient elder maltreatment screen was negative and no further follow-up required)	☐	☐	G8537
Document reason here and in medical chart. _____ _____ _____			If **No** is checked for **all** of the above, report G8536 (No documentation of an elder maltreatment screen, reason not specified) **OR** G8538 (Elder maltreatment screen documented, follow-up plan not documented, reason not specified)

[1]The Elder Maltreatment screen includes a review of the following components : 1) physical abuse, 2) emotional or psychological abuse, 3) neglect, 4) sexual abuse, 5) abandonment, 6) financial or material exploitation, 7) self-neglect, and 8) unwanted control.

[2]A follow up plan may include but is not limited to: documentation of a referral or discussion with other providers, ongoing monitoring or assessment, and/or a direct intervention

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