

Elder Maltreatment Screen and Follow-Up Plan

*This measure is to be reported at **each visit** during the reporting period for all patients aged 65 years and older.*

Measure description

Percentage of patients age 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan

What will you need to report at each visit for each patient aged 65 years and older for this measure?

Whether or not you screened for elder maltreatment and documented¹ a follow up plan, if necessary.

- The screen includes a review of the following components²:
 - 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.
- 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

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to screen for elder maltreatment, due to:

- Documented reasons (eg, not an initial visit³, patient refuses to participate, patient is in an urgent or emergent situation and to delay treatment would jeopardize the patient's health status).

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

¹Documented — Evidenced in the clinical record. Such evidence can include narrative notes, a formal screen and/or an assessment and treatment plan tool/form, copy of a documented plan or referral request for further evaluation, etc.

²Physical Abuse — Infliction of physical injury by punching, beating, kicking, biting, burning, shaking or other actions that result in harm. (Institute of Medicine, 2002)

Emotional or Psychological Abuse — Involves psychological abuse, verbal abuse, or mental injury and includes act or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect — Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being. (Reyes-Ortiz 2001)

Active — Behavior that is willful, the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts. (NCPEA)

Passive — Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources. (NCPEA)

Sexual Abuse — Involves adults who are unable to fully comprehend and/or give informed consent in sexual activities that violate the taboos of society. (Institute of Medicine 2002)

Abandonment — Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder. (NCPEA)

Financial or Material Exploitation — Taking advantage of a person for monetary gain or profit. (Institute of Medicine 2002)

Self-Neglect — Self-imposed attitudes or actions that contribute to decline in the persons overall health and well being, may be associated with an inappropriate or nontraditional lifestyle. Other names used may include Diogenes syndrome (DS), aged reclusion, social breakdown, and squalor syndrome. (Reyes-Ortiz 2001)

Unwarranted Control — Controlling a person's ability to make choices about living situations, household finances, and medical care. (Institute of Medicine 2002)

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

Elder Maltreatment Screen and Follow-Up Plan

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female
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.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT Procedure Code or a G-code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	G8534
Not screened for the following reason: • Documented reasons (ie, not an initial 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)	<input type="checkbox"/>	<input type="checkbox"/>	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)	<input type="checkbox"/>	<input type="checkbox"/>	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)

¹The 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.

²A 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

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

Elder Maltreatment Screen and Follow-Up Plan

Coding Specifications

Codes required to document a visit occurred:

A CPT Procedure 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 Procedure codes or G-codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 96116* (neurobehavioral status exam),
- 96150 (health and behavior assessment),
- 97003 (occupational therapy evaluation),
- 97802, 97803*, G0270* (medical nutrition therapy)

**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 visit¹ 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

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