Quality ID #181: Elder Maltreatment Screen and Follow-Up Plan

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 60 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.

INSTRUCTIONS:

Reporting Frequency:
This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:
This measure is intended to reflect the quality of services provided for patients screened for elder maltreatment. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

The documented follow-up plan must be related to positive elder maltreatment screening, example: “Patient referred for protective services due to positive elder maltreatment screening.” Cognitively impaired patients are included in the denominator of this measure and need to be screened using an elder maltreatment screening tool.

Telehealth:
NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the ‘Reference Coding’ section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more

CPT only copyright 2025 American Medical Association. All rights reserved.

information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 60 years and older.

DENOMINATOR NOTE:
**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 60 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 92002, 92004, 92012, 92014, 92517, 92518, 92519, 92521, 92522, 92523, 92524, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92548, 92549, 92550, 92551*, 92552, 92553, 92555, 92556, 92557, 92558, 92567, 92568, 92570, 92587, 92588, 92610, 92620, 92622, 92625, 92626, 92650*, 92651, 92652, 92653, 96105, 96116, 96125, 96127, 96130, 96132, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99401*, 99402*, 99403*, 99404*, 99424, 99483, 99487, 99490, 99491, 99492, G0101, G0102, G0270, G0323, G0402, G0438, G0439
WITHOUT
Encounters conducted via telehealth: M1437

NUMERATOR:
Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of the encounter and follow-up plan documented on the date of the positive screen.

Definitions:
Screen for Elder Maltreatment – An elder maltreatment screen should include assessment and documentation of one or more of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect (active or passive), (4) sexual abuse, (5) elder abandonment, (6) financial or material exploitation and (7) unwarranted control.

1. Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.
2. Emotional/Psychological Abuse – Willful infliction of mental or emotional anguish by threat, humiliation, isolation, or other verbal or nonverbal conduct.
3. 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.
    a. Active – Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.
    b. 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.
4. Sexual Abuse – Forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.
5. Elder 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.
6. Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit.
7. Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care.

NOTE: Self-neglect is a prevalent form of abuse in the elderly population. Screening for self-neglect is not

CPT only copyright 2025 American Medical Association. All rights reserved.

included in this measure. Resources for suspected self-neglect are listed below.

Follow-Up Plan – Must include a documented report to state or local Adult Protective Services (APS) or the appropriate state agency. Note: APS does not have jurisdiction in all states to investigate maltreatment of patients in long-term care facilities. In those states where APS does not have jurisdiction, APS may refer the provider to another state agency such as the state facility licensure agency for appropriate reporting.

- Federal reporting: In addition to state requirements, some types of providers are required by federal law to report suspected maltreatment. For example, nursing facilities certified by Medicare and/or Medicaid are required to report suspected maltreatment to the applicable State Survey and Certification Agency.
- For state-specific information to report suspected elder maltreatment, including self-neglect, the following resources are available:
    1. National Adult Protective Services Association - National Adult Protective Services Association Website--- (http://www.napsa-now.org)
    2. Eldercare Locater - 1-800-677-1116 – Elder Locator Website--- (https://eldercare.acl.gov/Public/Index.aspx)
    3. National Center on Elder Abuse - National Center on Elder Abuse Website--(https://ncea.acl.gov)

    Disclaimer: The follow-up plan recommendations set forth in this quality measure are not intended to supersede any mandatory state, local or federal reporting requirements.

Not Eligible (Denominator Exception) – A patient is "not eligible" if one or more of the following reasons is documented:

- Patient refuses to participate in the screening and has reasonable decisional capacity for self-protection.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment to perform the screening would jeopardize the patient's health status.

NUMERATOR NOTE:
Documentation of an elder maltreatment screening must include identification of the tool used. Examples of screening tools for elder maltreatment include, but are not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS), and Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST). These tools are psychometrically sound instruments with demonstrated reliability and validity indices.

Numerator Options:

Performance Met:	Elder maltreatment screen documented as positive AND a follow-up plan is documented (G8733)
OR	
Performance Met:	Elder maltreatment screen documented as negative, follow-up is not required (G8734)
OR	
Denominator Exception:	Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter related to one of the following reasons: (1) Patient refuses to participate in the screening and has reasonable decisional capacity for self-protection, or (2) Patient is in an urgent or emergent situation where time is of the essence and to delay treatment to perform the screening would jeopardize the patient's health status (G8535)
OR	
Performance Not Met:	No documentation of an elder maltreatment screen, reason not given (G8536)
OR	
Performance Not Met:	Elder maltreatment screen documented as positive, follow- up plan not documented, reason not given (G8735)

CPT only copyright 2025 American Medical Association. All rights reserved.

RATIONALE:

Mistreatment of older adults represents a widespread problem and elder maltreatment is being increasingly recognized as a global health issue. Screening for potential elder maltreatment provides a method of identifying those who may be at risk and provides an opportunity for interventions to be instituted to decrease further incidence, decrease or prevent harm, and improve the overall quality of life for the elderly victim and their family and/or caregiver(s). Identification and proper interventions would assist in providing support to the elderly patient and their family or caregiver(s) [1]. Providing support and early institution of interventions could potentially prevent actual abuse. The American College of Obstetricians and Gynecologists (ACOG) published a Committee Opinion in 2021 stating that ACOG "supports screening of patients older than 60 years to help identify victims of abuse and provide them with appropriate medical and psychosocial care and referrals" [2].

Elder maltreatment has been largely overlooked and has been a contributing factor to the health and well-being of the elderly population. Healthcare providers should screen patients routinely for abuse and neglect. The process of standardized screening using one or a combination of validated assessment(s) and/or instrument(s) should be done to ensure that signs of abuse or neglect are not overlooked. Tools that aim to detect elder mistreatment in areas such as safety access, cognitive and emotional status, health and functional status, social and financial resources, and frequency, severity, and intent are recommended to be utilized. Assessment tools contribute to the identification of the factors linked in the development of elder abuse and, therefore, facilitate early interventions to prevent patient mortality or negative patient outcomes. Screening tools for elder abuse have the ability to provide a multidisciplinary objective assessment to detect potential elder abuse [3].

Rosay and Mulford reviewed self-report data from the 2010 National Intimate Partner and Sexual Violence Survey (NISVS) to produce weighted estimates for past-year occurrences of abuse. Results from regression analysis showed "more than 1 in 10 adults who are 70 years of age or older (14.0%) have experienced some form of abuse in the past year, with 12.1% experiencing psychological abuse and 1.7% experiencing physical abuse. One in five victims (20.8%) were abused by both intimate and nonintimate partners" [4]. Williams, Davis, and Acierno discussed "the number of people age 65 and older will triple to well over one billion or 16% of the world's population by 2050" [5].

Several studies noted that elder abuse is under-reported [6,7,8]. Health care providers represent one of the lowest proportions of those reporting elder maltreatment and a failure to report elder abuse is a missed opportunity. Dong states, "almost all U.S. states have mandatory reporting legislation requiring healthcare professionals to report reasonable suspicions of elder abuse to APS. Despite these laws, many healthcare professionals are reluctant to report elder abuse because of concerns about lack of time, limited knowledge, fear of offending the individual and family, and sense of inability to make a difference" [6]. Hirst et al. also included other factors related to under-reporting of abuse such as lack of protocols to identify elder abuse, liability concerns, and limited availability of resources [9].

Prevalence rates of elder abuse can vary across populations. With respect to race, Dong reported that Black older adults experienced higher rates of financial exploitation and psychological abuse (three times and four times respectively) as compared with other populations [6]. Similarly, Beach et al. found that African American older adults have a "significantly higher" risk of financial exploitation and "more than two times" the risk of psychological mistreatment as compared with non-African American counterparts [10]. Latino and Native American populations also experience higher rates of elder abuse as compared with the general population. A study found 40.4% of elder Latinos experienced some form of abuse and/or neglect within the previous year [11]. For Native Americans, Crowder, et al.'s meta-analysis found that rates of elder abuse range from 4.3% to 45.9% depending on study, location and tribal affiliation, though "large studies with comparison populations found higher rates" [12].

Diminished cognitive or physical functioning can impact both prevalence rates of elder abuse. Dong's review found prevalence rates ranging from 10% in populations without cognitive impairment to 47.3% in populations with dementia [6]. Burnes, et al. found that both physical and emotional abuse were "significantly less likely to occur in older adults with greater functional capacity" [13]. Additionally, at least one study suggests that cognitive impairment among older adults is a barrier to reporting elder abuse [14].

Elder abuse and neglect victims experience increased rates of hospitalization and use of behavioral health services. Abuse can contribute to the individuals decline, both mentally and physically, and ultimately lead to premature mortality [15]. Bond and Butler reported the cost of elder abuse annually is estimated in the tens of billions of dollars and can affect approximately 700,000 to 1.2 million elderly people [16]. A greater use of health resources is associated with elder abuse. Dong cites emergency room use, hospitalizations, and 30-day readmissions as areas where health care use has been impacted. Costs such as physical and psychological injury, exacerbation of health problems, increased mortality risk, and untimely or early nursing home placement contribute to the overall cost of elder abuse [6].

CPT only copyright 2025 American Medical Association. All rights reserved.

CLINICAL RECOMMENDATION STATEMENTS:

Common types of elder mistreatment are physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect. Prevention, detection, and intervention strategies are essential to guard older adults from abuse and neglect in these areas. The use of standardized tools is supported and provides a common approach to assess older adults for abuse and neglect. Adult Protective Serves (APS) is a supported intervention that investigates alleged cases of abuse for older adults [17].

Risk assessment and mitigation tools should be utilized in the health care setting to examine patients for elder abuse and neglect (EAN). Once EAN is identified, notification of Adult Protective services (APS) is recommended as a best practice. Screening assists the health care professional in better identifying an individual's areas of needs, categorizing the individual's risk, and developing a multidisciplinary plan to provide appropriate interventions and support [18]. Care of the elder abuse and neglect victims should be a multidisciplinary approach and include the facilitation of access to supportive services.

According to evidence, all healthcare providers should screen patients older than 60 routinely to help identify victims of abuse and provide them with appropriate medical and psychosocial care and referrals (e.g., ACOG 2021) [2]. The process of standardized screening using any assessment or instrument should be done to ensure that signs of abuse or neglect are not overlooked [3]. However, current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect where there are no recognized signs and symptoms of abuse [19].

Strategies for detecting elder mistreatment include using a combination of physical assessment, subjective information, and data gathered from screening instruments. Providers should provide older adults with emergency contact numbers and community resources. When appropriate, referrals to regulatory agencies should be made. From implementing these recommendations, potential benefits include a reduction in harm of elderly patients through appropriate referrals as well as increased use of interventions to promote patient safety. For health care providers, potential benefits of screening through use of instruments or screening tools such as the Modified Caregiver Strain Index and Geriatric Depression Scale could improve evaluations and patient management that may also develop positive relationships between caregiver and older adult patients [20].

Whenever possible, clinicians should use judgement regarding the need to seek corroborating information from family members, caregivers, and/or care facility staff for patient reports during elder abuse screening for individuals with cognitive impairment.

REFERENCES:

1. Schofield, M. J. (2017). Screening for elder abuse: Tools and effectiveness. Elder Abuse, 161-199.
2. Committee on Health Care for Underserved Women. (2021). Elder Abuse and Women's Health. American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/elder-abuse-and-womens-health
3. Gallione, C., Dal Molin, A., Cristina, F. V. B., Ferns, H., Mattioli, M., & Suardi, B. (2017). Screening tools for identification of elder abuse: a systematic review. Journal of Clinical Nursing, 26(15-16), 2154–2176. https://doi.org/10.1111/jocn.13721
4. Rosay, A. B., & Mulford, C. F. (2016). Prevalence estimates and correlates of elder abuse in the United States: The National Intimate Partner and Sexual Violence Survey. Journal of Elder Abuse & Neglect, 29(1), 1–14. https://doi.org/10.1080/08946566.2016.1249817
5. Williams, J. L., Davis M. T., & Acierno, R. (2017). Global Prevalence of Elder Abuse in the Community. Elder Abuse, 45-65
6. Dong, X. Q. (2015). Elder Abuse: Systematic Review and Implications for Practice. Journal of the American Geriatrics Society, 63(6), 1214–1238. https://doi.org/10.1111/jgs.13454
7. Pillemer, K., Connolly, M. T., Breckman, R., Spreng, N., & Lachs, M. S. (2015). Elder Mistreatment: Priorities for Consideration by the White House Conference on Aging. The Gerontologist, 55(2), 320–327. https://doi.org/10.1093/geront/gnu180
8. Ferrah, N., Murphy, B. J., Ibrahim, J. E., Bugeja, L. C., Winbolt, M., LoGiudice, D., … Ranson, D. L. (2015). Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review. Age and Ageing, 44(3), 356–364. https://doi.org/10.1093/ageing/afv004
9. Hirst, S. P., Penney, T., McNeill, S., Boscart, V. M., Podnieks, E., & Sinha, S. K. (2016). Best-Practice Guideline on the Prevention of Abuse and Neglect of Older Adults. Canadian Journal on Aging = La Revue Canadienne Du

CPT only copyright 2025 American Medical Association. All rights reserved.

Vieillissement, 35(2), 242–260. https://doi.org/10.1017/S0714980816000209
10. Beach, S. R., Schulz, R., Castle, N. G., & Rosen, J. (2010). Financial Exploitation and Psychological Mistreatment Among Older Adults: Differences Between African Americans and Non-African Americans in a Population-Based Survey. The Gerontologist, 50(6), 744–757. https://doi.org/10.1093/geront/gnq053
11. DeLiema, M., Gassoumis, Z. D., Homeier, D. C., & Wilber, K. H. (2012). Determining Prevalence and Correlates of Elder Abuse Using Promotores: Low-Income Immigrant Latinos Report High Rates of Abuse and Neglect. Journal of the American Geriatrics Society, 60(7), 1333–1339. https://doi.org/10.1111/j.1532-5415.2012.04025.x
12. Crowder, J., Burnett, C., Laughon, K., & Dreisbach, C. (2019). Elder Abuse in American Indian Communities: An Integrative Review. Journal of Forensic Nursing, 15(4), 250–258. https://doi.org/10.1097/jfn.0000000000000259
13. Burnes, D., Pillemer, K., Caccamise, P. L., Mason, A., Henderson, C. R., Berman, J., … Lachs, M. S. (2015). Prevalence of and Risk Factors for Elder Abuse and Neglect in the Community: A Population-Based Study. Journal of the American Geriatrics Society, 63(9), 1906–1912. https://doi.org/10.1111/jgs.13601
14. Richmond, N. L., Zimmerman, S., Reeve, B. B., Dayaa, J. A., Davis, M. E., Bowen, S. B., … Platts-Mills, T. F. (2020). Ability of Older Adults to Report Elder Abuse: An Emergency Department–Based Cross-Sectional Study. Journal of the American Geriatrics Society, 68(1), 170–175. https://doi.org/10.1111/jgs.16211
15. Yunus, R. M., Hairi, N. N., Choo, W. Y., Hairi, F. M., Sooryanarayana, R., Ahmad, S. N., … Bulgiba, A. (2016). Mortality among elder abuse victims in rural Malaysia: A two-year population-based descriptive study. Journal of Elder Abuse & Neglect, 29(1), 59–71. https://doi.org/10.1080/08946566.2016.1260083
16. Bond, M. C., & Butler, K. H. (2013). Elder Abuse and Neglect. Clinics in Geriatric Medicine, 29(1), 257–273. https://doi.org/10.1016/j.cger.2012.09.004
17. Fearing, G., Sheppard, C. L., McDonald, L., Beaulieu, M., & Hitzig, S. L. (2017). A systematic review on community-based interventions for elder abuse and neglect. Journal of Elder Abuse & Neglect, 29(2–3), 102–133. https://doi.org/10.1080/08946566.2017.1308286
18. Moore, C., & Browne, C. (2016). Emerging Innovations, Best Practices, and Evidence-Based Practices in Elder Abuse and Neglect: a Review of Recent Developments in the Field. Journal of Family Violence, 32(4), 383–397. https://doi.org/10.1007/s10896-016-9812-4
19. Recommendation: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening | United States Preventive Services Taskforce. (2018, October 23). Retrieved from https://uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
20. Fulmer, T., & Caceres, B. A. (2012). Mistreatment Detection, Evidence-Based Geriatric Nursing Protocols for Best Practice, (Fourth Edition p. 544 – 661). New York, United States: Springer Publishing.

COPYRIGHT:
THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.
©
This measure is owned and stewarded by the Centers for Medicare & Medicaid Services (CMS). CMS contracted (Contract # 75FCMC18D0027/ Task Order # 75FCMC24F0144) with the American Institutes for Research (AIR) to develop this measure. AIR is not responsible for any use of the Measure. AIR makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and AIR has no liability to anyone who relies on such measures or specifications. This measure is in the public domain.

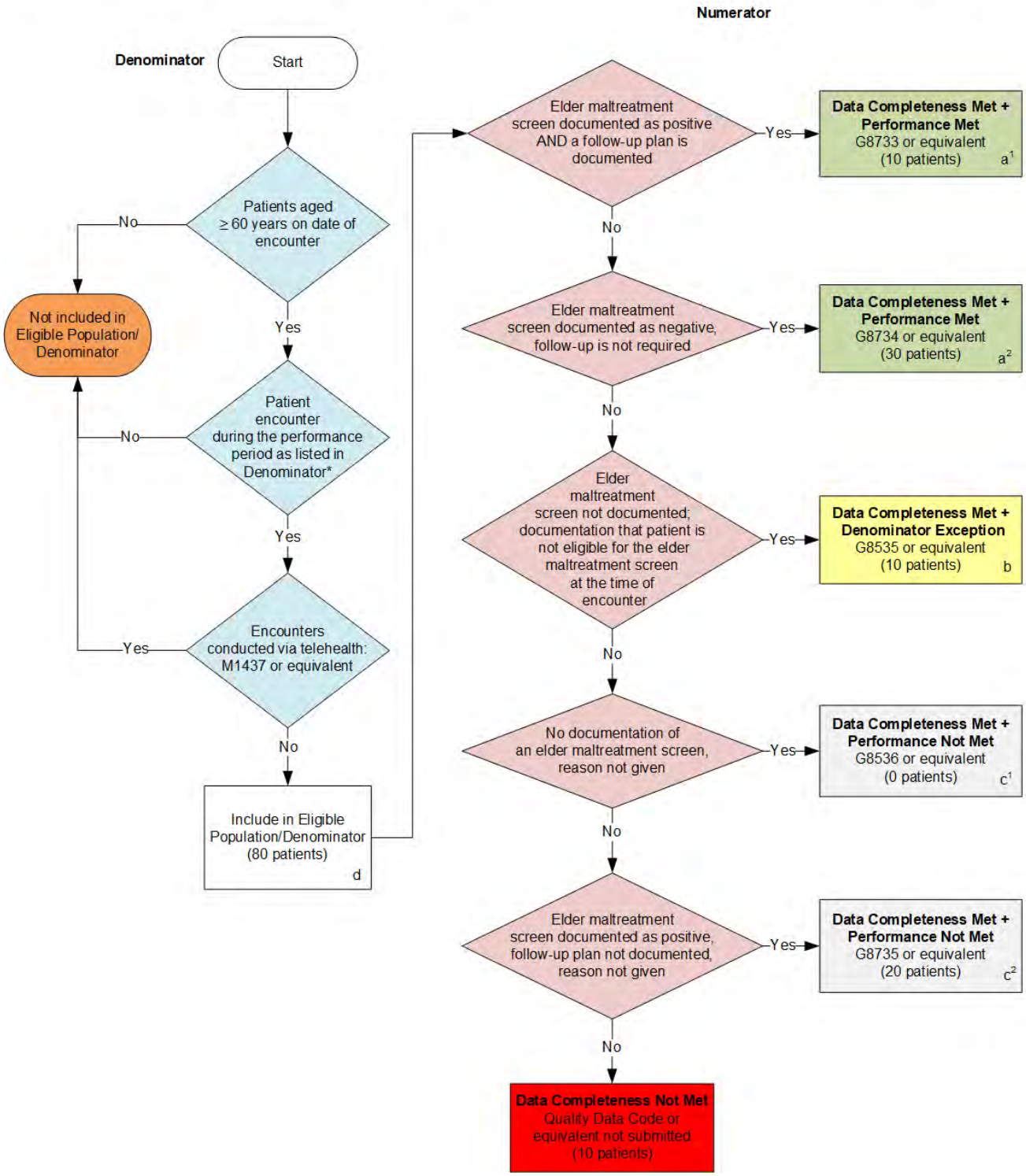
Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. AIR disclaims all liability for use or accuracy of any third party codes contained in the specifications.

CPT® contained in the measure's specifications is copyright 2004-2025 American Medical Association. ICD-10 copyright 2025 World Health Organization. All Rights Reserved.

This performance measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications.

2026 Clinical Quality Measure Flow for Quality ID #181: Elder Maltreatment Screen and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



CPT only copyright 2025 American Medical Association. All rights reserved.

SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met } (a^1+a^2=40 \text{ patients}) + \text{Denominator Exception } (b=10 \text{ patients}) + \text{Performance Not Met } (c^1+c^2=20 \text{ patients})}{\text{Eligible Population / Denominator } (d=80 \text{ patients})} = \frac{70 \text{ patients}}{80 \text{ patients}} = \mathbf{87.50\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=40 \text{ patients})}{\text{Data Completeness Numerator } (70 \text{ patients}) - \text{Denominator Exception } (b=10 \text{ patients})} = \frac{40 \text{ patients}}{60 \text{ patients}} = \mathbf{66.67\%}$$

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

CPT only copyright 2025 American Medical Association. All rights reserved.
The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

v10

CPT only copyright 2025 American Medical Association. All rights reserved.

2026 Clinical Quality Measure Flow Narrative for Quality ID #181: Elder Maltreatment Screen and Follow-Up Plan

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *Patients aged greater than or equal to 60 years on date of encounter*:
    a. If *Patients aged greater than or equal to 60 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 60 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Encounters conducted via telehealth*.
4. Check *Encounters conducted via telehealth*:
    a. If *Encounters conducted via telehealth* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.
    b. If *Encounters conducted via telehealth* equals No, include in *Eligible Population/Denominator*.
5. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Elder maltreatment screen documented as positive AND a follow-up plan is documented*:
    a. If *Elder maltreatment screen documented as positive AND a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[1] equals 10 patients in the Sample Calculation.
    b. If *Elder maltreatment screen documented as positive AND a follow-up plan is documented* equals No, proceed to check *Elder maltreatment screen documented as negative, follow-up is not required*.
8. Check *Elder maltreatment screen documented as negative, follow-up is not required*:
    a. If *Elder maltreatment screen documented as negative, follow-up is not required* equals Yes, include in *Data Completeness Met and Performance Met.*

CPT only copyright 2025 American Medical Association. All rights reserved.

- *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 30 patients in the Sample Calculation.

b. If *Elder maltreatment screen documented as negative, follow-up is not required* equals No, proceed to check *Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of encounter*.

9. Check *Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of encounter*:

   a. If *Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of encounter* equals Yes, include in *Data Completeness Met and Denominator Exception.*

      - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 patients in the Sample Calculation.

   b. If *Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of encounter* equals No, proceed to check *No documentation of elder maltreatment screen, reason not given*.

10. Check *No documentation of elder maltreatment screen, reason not given*:

    a. If *No documentation of elder maltreatment screen, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

       - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 0 patients in the Sample Calculation.

    b. If *No documentation of elder maltreatment screen, reason not given* equals No, proceed to check *Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given*.

11. Check *Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given*:

    a. If *Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

       - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 20 patients in the Sample Calculation.

    b. If *Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given* equals No, proceed to check *Data Completeness Not Met.*

12. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

CPT only copyright 2025 American Medical Association. All rights reserved.

Sample Calculations:

Data Completeness equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b equals 10 patients) plus Performance Not Met (c^1 plus c^2 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

CPT only copyright 2025 American Medical Association. All rights reserved.