Final Version 3 CMS-416 Instructions

Effective for reporting to CMS by April 1, 2015 (10/1/13-9/30/14)

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CMS-416 and Instructions

- **Form CMS-416:** http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

- **Final CMS-416 Instructions Version 3 Updated 11/17/2014:** http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf

Version 3 of CMS-416 Instructions

The two primary changes to Version 3 of the revised instructions are:

- States can count unduplicated unpaid and denied claims, in addition to paid claims, for a service that was provided, as long as the service is only counted once. The section in the instructions on ***Important Reporting Requirements*** explains the circumstances in which unduplicated unpaid and denied claims can be counted. Language was also added to the instructions for all lines for services, to permit unduplicated paid, unpaid, or denied claims.

- The CPT-CDT crosswalk was removed from the instructions because CMS has concerns about the completeness and accuracy of the CPT codes listed in the crosswalk that we are unable to fully vet at this time. We will post the crosswalk in a separate document on the EPSDT page of Medicaid.gov, with the caveat that it is not complete and states must be able to report only data for dental services when using CPT data on the CMS-416.

CMS-416 Submission to CMS

- **Effective Date** – These revised instructions must be used for the reporting period federal fiscal year 2014, beginning October 1, 2013 through September 30, 2014, for data due to CMS on the form CMS-416 on or before April 1, 2015. States have difficulty with this deadline should inform CMS ASAP.

- **Submittal Procedure** – States must submit the annual form CMS-416 on the prescribed electronic template **and** your state medical **and** dental periodicity schedules via email to the CMS central office via the EPSDT mailbox at EPSDT@cms.hhs.gov not later than April 1.

- States can submit a brief cover email accompanying the CMS-416 report to explain any state data or program changes, for inclusion in a separate footnotes page accompanying the national and state data reports.

Key Changes to 416 Instructions

Important Reporting Requirements precede line item instructions.

- Data on visits are based on paid, unpaid, and denied claims, within defined parameters in the instructions.
- Line 11 (*Total Eligibles Referred for Corrective Treatment*) instructions now count most but not all visits within 90 days of an initial or periodic visit.
- Notes for the dental lines 12a-12g are expanded to define dental services and oral health services, to add certain dental codes, and to explain when individuals can be counted and not counted on specific lines.
- Instructions for lines 13 (*Total Eligibles Enrolled in Managed Care*) and 14 (*Total Number of Screening Blood Lead Tests*) limit the count of eligibles in the denominator to individuals enrolled for at least 90 continuous days during the reporting period.
- ICD-10 codes for lines 6 and 14 are included in Appendix 1.

Appendix 1: Crosswalk of ICD-9 Codes to ICD-10 Codes

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.0 Toxic effect of inorganic lead compounds	T56.0X1A Toxic effect of lead and its compounds, accidental (unintentional), initial encounter T56.0X2A Toxic effect of lead and its compounds, intentional self-harm, initial encounter T56.0X3A Toxic effect of lead and its compounds, assault, initial encounter T56.0X4A Toxic effect of lead and its compounds, undetermined, initial encounter
984.1 Toxic effect of organic lead compounds	T56.0X1A Toxic effect of lead and its compounds, accidental (unintentional), initial encounter T56.0X2A Toxic effect of lead and its compounds, intentional self-harm, initial encounter T56.0X3A Toxic effect of lead and its compounds, assault, initial encounter T56.0X4A Toxic effect of lead and its compounds, undetermined, initial encounter
984.8 Toxic effect of other lead compounds	T56.0X1A Toxic effect of lead and its compounds, accidental (unintentional), initial encounter T56.0X2A Toxic effect of lead and its compounds, intentional self-harm, initial encounter T56.0X3A Toxic effect of lead and its compounds, assault, initial encounter T56.0X4A Toxic effect of lead and its compounds, undetermined, initial encounter

Important Reporting Requirements

- Report age based on the individual's age as of September 30 of the reporting year:

<1	1-2	3-5	6-9	10-14	15-18	19-20

- Report all data in the age category of the individual's age at the end of the federal fiscal year, even if the individual received services in two age categories. For example, if a child turned age 3 on September 1st, but had a 30-month well-child visit in March, the 30-month visit would be counted in the age 3-5 category.
- Screening data on Line 3a through Line 14 should reflect unduplicated counts of individuals from **Line 1b** (individuals enrolled for at least 90 continuous days during the reporting period).
- All screening and services lines are a subset of line 1b: *(Total Individuals Eligible for EPSDT for 90 Continuous Days).*
- Report data on visits based on **paid, unpaid, and denied claims**, within defined parameters in the instructions.

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	Fiscal Year								
		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
2a. State Periodicity Schedule									
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			0.00	0.00	0.00	0.00	0.00	0.00	0.00
3a. Total Months of Eligibility	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
3b. Average Period of Eligibility	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

4. Expected Number of Screenings per Eligible	CN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
5. Expected Number of Screenings	CN:	0	0	0	0	0	0	0	0
	MN:	0	0	0	0	0	0	0	0
	Total:	0	0	0	0	0	0	0	0
6. Total Screens Received	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
7. SCREENING RATIO	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	0	0	0	0	0	0	0	0
	MN:	0	0	0	0	0	0	0	0
	Total:	0	0	0	0	0	0	0	0
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
10. PARTICIPANT RATIO	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11. Total Eligibles Referred for Corrective Treatment	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0

12a. Total Eligibles Receiving Any Dental Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12b. Total Eligibles Receiving Preventive Dental Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12c. Total Eligibles Receiving Dental Treatment Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	0							
	MN:	0							
	Total:	0				0	0		
12e. Total Eligibles Reciving Dental Diagnostic Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Reciving Any Dental Or Oral Health Service	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
13. Total Eligibles Enrolled in Managed Care	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
14. Total Number of Screening Blood Lead Tests	CN:	0							
	MN:	0							
	Total:	0	0	0	0				
* Includes 12-month visit									
Note: "CN"=Categorically Needy, "MN"= Medically Needy									

NOTE B: Dental Lines 12a – 12g

- “Dental services” refers to services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state’s dental practice act.
- “Oral health services” refers to services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist.
- For each dental line, the universe of appropriate procedure codes to report is provided in the instructions below (HCPCS or equivalent CDT codes) or in Table 1 (CPT).

Line 12b: *Total Eligibles Receiving Preventive Dental Services*

Enter the **unduplicated** number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one preventive dental service by or under the supervision of a dentist as defined by **HCPCS codes D1000 – D1999 (or equivalent CDT codes D1000 – D1999) or the equivalent CPT codes**. See Notes A and B.

Further Clarifications to CMS-416

- **Line 14** *Screening Blood Lead Tests* – CPT code 83655 is the *procedure* code used to identify that a blood lead test was performed. To identify a person receiving a screening blood lead test, this code should be accompanied on the claim by a *diagnosis* code of V15.86 (exposure to lead) or V82.5 (special screening for other conditions such as a screening for heavy metal poisoning). **States are not limited to these two diagnosis codes.**

- **Eligibility Categories** – State eligibility staff should reference the Transformed Medicaid Statistical Information System (T-MSIS) Data Dictionary at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-and-chip-operational-data.html

- **90 Continuous Days of Eligibility** – Criterion added on service lines to allow sufficient time for enrollment in managed care, and services provided and counted.

- **Payment arrangements** include services provided by managed care entities, primary care provider, or primary care case manager, regardless of whether reimbursement to the provider is fee-for-service or capitated, and also includes prospective payment arrangements or other arrangements based on encounters.

- **Effective Date of CMS-416 Instructions** – A header was added on each page: "Instructions for Form CMS-416 Annual EPSDT Participation Report" and **"**Effective for reporting periods beginning with federal fiscal year 2014 (October 1, 2013 through September 30, 2014), with submission of Form CMS-416 by April 1, 2015." A footer was added to give the date of the most recent version.

Final Version 3 CMS-416 Instructions

Thank you!

Send your question(s) to the EPSDT mailbox:
EPSDT@cms.hhs.gov

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