2700.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

A. Purpose -- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a State's screening periodicity schedule.

The completed report demonstrates the State's attainment of its participation and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on the form CMS-416. From the completed reports, trend patterns and projections are developed for the nation and for individual States or geographic areas, from which decision and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirement -- Each State that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date -- The form CMS-416 effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990.

D. Submittal Procedure -- **Submit original form CMS–416 and your State periodicity schedule to the CMS central office and one copy to the appropriate regional office not later than April 1 of the year following the end of the Federal fiscal year being reported.** Your cover letter should be addressed to CMS central office and include an explanation of the data that comprised the report. Send the report to: Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, S2-01-16, 7500 Security Blvd., Baltimore, MD 21244. The format to be used in submitting the form CMS-416 is supplied in Exhibit A.

E. Detailed Instructions -- For each of the following line items, report total counts by the age groups indicated and by whether categorically and medically needy. In cases where calculations are necessary, perform separate calculations for the total column and each age group. **Report age based upon the child's age as of September 30.**

State. Enter the name of your State.

Fiscal Year. Enter the Federal fiscal year being reported.

Line 1 -- Total Individuals Eligible for EPSDT -- Enter the total unduplicated number of all individuals under the age of 21 determined to be eligible for EPSDT services, distributed by age and by basis of Medicaid eligibility. "Unduplicated" means that an eligible person is reported only once although he/she may have had more than one period of eligibility during the year. Include all individuals regardless of whether the services are provided under the fee-for-service

arrangements or under managed care arrangements. States should determine basis of eligibility consistent with the instructions for form CMS-2082. Medicaid-eligible individuals under age 21 are considered eligible for EPSDT services regardless of whether they have been informed about the availability of EPSDT services or whether they accept EPSDT services at the time of informing. Individuals for whom third-party liability is available should also be counted in the number.

Do not include in this count the following groups of individuals: 1) medically needy individuals under the age of 21 if you do not provide EPSDT services for the medically needy population; 2) individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available; 3) undocumented aliens who are eligible only for emergency Medicaid services; or 4) other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

Line 2a - State Periodicity Schedule -- Enter the number of initial or periodic general health screenings required to be provided to individuals within the age group specified according to the State's periodicity schedule. (Example: If your State periodicity schedule requires screening at 12, 18 and 24 moth, the number 3 should be entered in the 1-2 age group column.) **Make no entry in the total column.**

Note: Use the State's most recent periodicity schedule and attach a copy to the completed report for submittal to CMS.

Line 2b - Number of Years in Age Group -- **Make no entries on this line.** This is a fixed number reflecting the number of years included in each age group.

Line 2c - Annualized State Periodicity Schedule -- Divide line 2a by the number in line 2b. Enter the quotient. This is the number of screenings expected to be received by an individual in each age group in one year. **Make no entry in the total column.**

Line 3a - Total Months of Eligibility -- Enter the total months of eligibility for the individuals in each age group in line 1 during the reporting year.

Line 3b - Average Period of Eligibility -- Divide line 3a by the number in line 1. Divide that number by 12 and enter the quotient. This number represents the portion of the year that individuals remain Medicaid eligible during the reporting year, regardless of whether eligibility was maintained continuously.

Line 4 - Expected Number of Screenings per Eligible -- Multiply line 2c by line 3b. Enter the product. This number reflects the expected number of initial or periodic screenings per child per year based on the number required by the State-specific periodicity schedule and the average period of eligibility. **Make no entries in the total column.**

Line 5 - Expected Number of Screenings -- Multiply line 4 by line 1. Enter the product. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1.

~~Line 6 - Total Screens Received - Enter the total number of initial or periodic screens furnished to eligible individuals under either fee-for-service or managed care arrangements.~~

~~**Note: Use the CPT codes listed below or any State-specific EPSDT codes you may have developed in your state as a proxy for reporting these screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients.**~~

Line 6 - Total Screens Received - Enter the total number of initial or periodic screens furnished to eligible individuals under fee-for-service and managed care arrangements.

NOTE: States may use the CPT codes listed below as a proxy for reporting these screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients. (Newborn codes 99431 and 99432 are scheduled to change in January 2009. At that time, States should use the new codes for newborn care services.)

This number should not reflect sick visits or episodic visits provided to children unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal State periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch-up EPSDT screening is defined as a complete screening that is provided to bring a child up-to-date with the State's screening periodicity schedule.) Use data reflecting **date of service** within the fiscal year for such screening services or other documentation of such services furnished under capitated arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

CPT-4 codes: Preventive Medicine Services
99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39 years)
99391 Established patient under one year
99392 Established patient (ages 1-4 years)
99393 Established patient (ages 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99431 Newborn care (history and examination)
99432 Normal newborn care
or
CPT-4 codes: Evaluation and Management Codes
99202-99205 New Patient
99213-99215 Established Patient

NOTE: These CPT-4 codes must be used in conjunction with codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

Line 7 - Screening Ratio - Divide the actual number of initial and periodic screening services received (line 6) by the expected number of initial and periodic screening services (line 5). This ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule, adjusted by the proportion of the year for which they are Medicaid eligible.

Note: In calculating Line 7, note that Line 6 should not exceed Line 5. The ratio cannot be over 100%.

Line 8 - Total Eligibles Who Should Receive at Least One Initial or Periodic Screen - The number of persons who should receive at least one initial or periodic screen is dependent on each State's periodicity schedule. Use the following calculations:

1. Look at the number entered in line 4 of this form, if that number is greater than 1, use the number 1. If the number in line 4 is less than or equal to 1, use the number in line 4. (This procedure will eliminate situations where more than one visit is expected in any age group in a year.).

2. Multiply the number from calculation 1 above by the number in line 1 of the form. Enter the product on line 8. Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen - Enter the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year. Refer to codes in line 6.

Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen - Enter the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year. **Refer to codes in line 6.**

Line 10 - Participant Ratio - Divide line 9 by line 8. Enter the quotient. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

Note: In calculating Line 10, note that Line 9 should not exceed Line 8. The ratio cannot be over 100%.

Line 11 - Total Eligibles Referred for Corrective Treatment - Enter the unduplicated number of individuals, including those in managed care arrangements, who, as the result of at least one health problem identified during an initial or periodic screening service, including vision and hearing screenings, were scheduled for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment services. This element does not include correction of health problems during the course of a screening examination.

Line 12a - Total Eligibles Receiving Any Dental Services - Enter the unduplicated number of children receiving any dental service as defined by ADA codes D0100 - D9999. "Unduplicated" means that each child is counted only once for purposes of this line even if multiple services were received.

Line 12b - Total Eligibles Receiving Preventive Dental Services - Enter the unduplicated number of children receiving a preventive dental service as defined ADA codes D1000 - D1999.

"Unduplicated" means that each child is counted only once even if more than one preventive service was provided.

Line 12c - Total Eligibles Receiving Dental Treatment Services - Enter the unduplicated number of children receiving treatment services as defined by ADA codes D2000 - D9999). “Unduplicated” means that each child is counted only once even if more than one treatment service was provided.

Line 12d – Total Eligibles Receiving Dental Diagnostic Services – Enter the unduplicated number of children receiving diagnostic services as defined by ADA code D0100 – D0999. “Unduplicated” means that each child is counted only once even if more than one diagnostic service was provided.

Line 12e – Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider – Enter the unduplicated number of children receiving oral health services as defined by an ADA code furnished by a licensed provider that is not a dentist (e.g., a pediatrician furnishing a fluoride varnish or a dental hygienist not under the supervision of a dentist furnishing a prophylaxis). These are only examples and are not intended to limit your reporting. Actual providers may vary by State Practice Acts. “Unduplicated” means that each child is counted only once even if more than one diagnostic service was provided.

Line 12f – Total Eligibles Receiving any Dental or Oral Health Service – Add lines 12a and 12e. Enter the total unduplicated number of children receiving any dental or oral health service as defined by ADA code D0100 – D9999 by a dentist or other licensed provider as allowed by your State Practice Act.

NOTE: For purposes of reporting the information on dental services, "unduplicated" means that each child is counted once for each line of data requested. **For example, a child is counted once on line 12a for receiving any dental service, counted on line 12c if the child received a treatment dental service and counted again on line 12e if the child received an oral health service by a non-dentist.** These numbers should reflect services received in fee-for-service and managed care arrangements.

~~Lines 12b and 12c do not equal to total services reflected in line 12a.~~

Line 13 - Total Eligibles Enrolled in Managed Care - This number is reported for informational purposes only. This number represents all individuals eligible for EPSDT services in your State who are enrolled in any type of managed care arrangement at any time during the reporting year. It includes any capitated arrangements such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager regardless of whether reimbursement is fee-for-service or capitated. Include these individuals in the total number of eligibles on line 1; include the number of initial or periodic screenings provided to these individuals in lines 6 and 8 for purposes of determining the State's screening and participation rates. The number of individuals referred for corrective treatment and receiving dental services are reflected in lines 11 and 12a-f, respectively.

Line 14 - Total Number of Screening Blood Lead Tests - Enter the total number of screening blood lead tests furnished to eligible individuals under the fee-for-service or managed care arrangement. Follow-up blood tests performed on individuals who have

been diagnosed or are being treated for lead poisoning should not be counted. You may calculate the number of blood lead screenings in two ways: 1) count the number of times CPT code 83655 ("lead") for a blood lead test is reported with certain ICD-9-CM codes (see note below); or 2) you may elect to use the HEDIS measure developed by NCQA to report blood lead screenings if your State has chosen to use this performance measure. Do not make entries in the shaded columns.

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. Code 83655 when 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) may be used to identify a person receiving a screening blood test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984(.0-.9) (toxic effect of lead and its compounds) or E861.6 (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning.

~~Line 14 - Total Number of Screening Blood Lead Tests - Enter the total number of screening blood lead tests furnished to eligible individuals under the fee-for-service or managed care arrangement. Do not count blood lead tests done on persons who have been diagnosed or treated for lead poisoning.~~ ~~**Do not make entries in the shaded columns.**~~

~~To report number of screening blood lead tests do the following: Count the number of times CPT code 83655 ("lead") or any State-specific (local) codes used for a blood lead tests reported with any ICD-9-CM except with diagnosis codes 984 (.0-.9)("Toxic Effects of Lead and Its Compounds"), E861.5 ("Accidental Poisoning by Petroleum Products, Other Solvents and Their Vapors NEC: Lead Paints"), and E866.0 ("Accidental Poisoning by Other Unspecified Solid and Liquid Substances: Lead and Its Compounds and Fumes"). These specific ICD-9-CM diagnosis codes are used to identify people who are lead poisoned. Blood lead tests done in these individuals do not count as a screening blood lead test.~~

F. Disclosure Statement - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop: C4-26-05, Baltimore, Maryland 21244-1850.