Responses to Comments Received
August 9, 2013 Federal Register Notice on
CMS-416 and Revised Instructions
Effective October 1, 2014 for Federal Fiscal Year 2015

CMS received three sets of comments on the August 9, 2013 Federal Register notice on the renewal of authority to collect data on the Form CMS-416 and for the proposed changes to the instructions for the form. There are no changes proposed for the CMS-416 form at this time. The changes to the instructions are intended to:

- Clarify the instructions for ease of understanding and more accurate data reporting,
- Limit the count of individuals referred for corrective action on Line 11 - *Total Eligibles Referred for Corrective Treatment* - to those with a visit that occurs within 90 days after an initial or periodic screen,
- Add two new dental codes that can be used to capture oral health screening and assessment by medical professionals on the dental lines of the Form CMS-416, and
- Convert ICD-9 codes identified in the instructions to ICD-10 codes, as required by HIPAA, effective October 1, 2014.

The revised instructions are effective beginning with federal fiscal year 2015, for data due on or after April 1, 2016.

The commenters were Robert Isman, DDS, the American Dental Hygienists Association, and anonymous. The comments were all unique and primarily related to the instructions for completing the Form CMS-416 dental lines, lines 12a through 12g. CMS will respond to each comment individually.

Comment on Including a Definition for Federal Fiscal Year

One commenter asked that the instructions clearly state the definition of a federal fiscal year, to prevent confusion with the terminology.

CMS Response

We agree with this comment and have included clarifying language that, for example, Federal Fiscal Year 2015 means October 1, 2014, through September 30, 2015, for the CMS-416 report that is due to CMS on April 1, 2016.

Comment on Addition of a Notes Section for States to Explain Variations in Data

One commenter suggested including a notes section on Form CMS-416 for states to comment about issues affecting their data entries. For example, changes to a state's periodicity schedule can increase or decrease the participation ratio. Increasing the number of required visits for an age category would tend to cause the participation ratio to decline until providers come into compliance with the additional visit(s).

CMS Response

We agree that it is helpful for CMS, states, and researchers to understand reasons for variation in data, particularly when the variation is intended to update the periodicity schedule in accordance with Bright Futures™ guidelines and consultation with recognized medical and dental organizations involved in child health care on specificity of number of visits. Unfortunately, the CMS-416 database will not permit upload of the CMS-416 form if text has been added to it. Instead, we added language in the instructions that states may include such information, limited to 50 words, in the cover correspondence accompanying their CMS-416 submissions, and the information will be included in a separate footnotes document on the Medicaid.gov website accompanying the posted data reports.

Comment on Addition of Dental Participation Ratio Lines

One commenter suggested including dental participation ratio lines for preventive dental services and preventive treatment services, to show the extent to which eligibles are receiving these services based on the total population.

CMS Response

We appreciate the commenter's perspective with regard to a dental participation ratio for preventive dental and treatment dental services. Such a ratio would be comparable to the well-child visit participant ratio (line 10) on the CMS-416 that indicates the extent to which Medicaid eligibles are receiving any initial and periodic screening services during the federal fiscal year (FFY).

While not being considered for incorporation on the 416 form at this time, CMS already makes available similar information in various forms and formats. However, using data extracted from the CMS-416 (lines 1b, 12b, and 12c), *Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP* presents information on the percentage of eligibles receiving preventive dental services, and the percentage of children receiving dental treatment services (See pages A.41 - A.44 of the report).

Similarly, under the CMS Oral Health Initiative, CMS has computed a ratio using CMS-416 data (lines 1b and 12b) to establish state-specific and national goals for improvement, by FFY 2015, for children's receipt of preventive dental services.

CMS also periodically shares preventive dental and dental treatment trends using data from the CMS-416 through monthly Oral Health Technical Advisory Group calls; a recent CMCS Informational Bulletin provides examples of such trend analyses.

Comment on Note B for Dental Lines 12a-12g and Supervision of Dental Hygienists

One commenter suggested edits to Note B of the instructions for the dental lines, related to the characterization of dental hygienists who are not under the supervision of a dentist. The commenter noted that the important issue in determining that a hygienist is an "oral health" provider in the context of the CMS-416 report is to determine that the hygienist is not operating as an extension of a private dental office or clinic managed and/or owned by a dentist but is billing Medicaid for himself or herself as self-employed or under contract with an entity like a hospital or public health clinic.

The commenter further noted that each state that reimburses dental hygienists directly has already completed a process to identify under what circumstances a hygienist provides services independently of a dentist provider and CMS should instruct states to list the hygienist as an oral health provider if they directly reimburse the hygienist.

CMS Response

We disagree with the commenter's suggested edits to Note B. Following the rubric in the Medicaid regulations, the CMS-416 instructions differentiate between "dental services" and "oral health services" based on whether the dental professional is operating under any kind of supervision of a dentist. Public health supervision and collaborative practice supervision, though types of supervision, often are not connected to a private dental office or a clinic managed or owned by a dentist. For example, in some states the state's public health dental director operates as the supervising dentist for hygienists working under public health supervision. We do not agree with removing the list of types of supervision, because very few people understand that there is a broad range of supervision, and our intent is to clarify this.

We also disagree about making a change based on the assertion that states that reimburse dental hygienists have completed a process to identify whether a hygienist is providing services independently of a dentist. The oral health services reporting lines are not just about hygienists. They are also about medical professionals as well as dental therapists and other advanced dental practitioners. There are states that allow these practitioners to bill Medicaid directly even though they are working under the supervision of a dentist. Within the regulatory rubric the critical factor for inclusion on "dental services" lines versus "oral health services" lines is the supervision arrangement, not the billing arrangement. However, we will delete from the instructions the term "independent practice" that the commenter suggested we remove and instead rely on the phrase, "not under the supervision of a dentist." We clarified that the term "oral health services" refers to "services provided by a health care practitioner working within their scope of practice who is neither a dentist nor providing services under the supervision of a dentist."

Comment on Line12d - Definition of a Permanent Molar Tooth

One commenter suggested that instructions for Line 12d - *Total Eligibles Receiving a Sealant on a Permanent Molar Tooth* include the specific tooth numbers that qualify, to prevent any misinterpretation of a permanent molar tooth.

CMS Response

We agree with this comment and have added to the instructions for Line 12d the tooth numbers for permanent molar teeth, which are 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, tooth numbers 1, 16, 17, 32.

Comment on Line 12f - Inclusion of ICD-9 and ICD-10 Codes

One commenter suggested that, since CMS intends to include oral health services provided by a non-dentist provider, including a provider that is not under the supervision of a dentist, such as medical providers, and intends to allow use of ICD-9 or ICD-10 codes to identify those services, it would be helpful to include a list of the specific ICD-9 and ICD-10 codes that would qualify, as has been done with the screening blood lead test codes for Line 14.

CMS Response

While it is possible to include the ICD-9 and ICD-10 codes to help states identify services provided by non-dentist providers, it is not feasible to do so during this round of instructions revisions. We will consider including these codes in the next round of revisions.

Comment on Line 12f – Distinguishing Dental from Medical Provider Types

One commenter is concerned that the instructions for line 12f - *Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider* do not enable the report to quantify the services provided by dental hygienists and dental therapists versus non-dental health care providers, such as nurses, physicians and other medical personnel, even though the nature of the services provided by the two groups are significantly different in scope and comprehensiveness, and useful information for planning purposes is lost by grouping them together. The commenter notes that multiple provider types will be assuming a greater a role in providing oral health services in the future, and suggested that the report provide for data to be collected on the types of professionals who provide oral health services, such as M.D. (physician), RDH (hygienist who performs prophylaxis), DT (dental therapist), RN (registered nurse).

CMS Response

We acknowledge that it would be valuable to have services provided by non-dentists separated into the type of providers; however, the data are grouped together because of the limitations within CMS regulatory and data collection rules. We also must balance the value of the information with the data collection burden for states. We believe that it would be burdensome for states to report according to the type of non-dentist provider at this time, especially as we continue to focus on improvement of data accuracy.

Comment on the Crosswalk to Highlight Changes in the CMS-416 Instructions for Paperwork Reduction Act – related to Line 12e

One commenter noted that the crosswalk to highlight changes to instructions for line 12e - *Total Eligibles Receiving Diagnostic Dental Services*, that accompanied the August 9, 2013 Federal Register Notice indicates under **Type of Change** that CMS "Adds two new dental codes for diagnostic services that do not specify a dentist as the rendering provider, for which states can report on this line." The commenter finds that this language suggests that these two new codes can be used in line 12e to report services not provided by a dentist, yet the instructions for line 12e note that the diagnostic dental service must be provided by or under the supervision of a dentist. The commenter asks that this conflicting language be clarified.

CMS Response

The commenter is correct to note the problem in the crosswalk for changes to instructions for line 12e - *Total Eligibles Receiving Diagnostic Dental Services*. This information on the two new codes was intended to describe a change for line 12f - *Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider,* and was mistakenly placed in the crosswalk for line 12e rather than in line 12f. We have corrected the crosswalk for lines 12e and 12f.

In 2013, CMS introduced two new codes for diagnostic services that could be used for non-dentists such as medical providers and dental hygienists. Only if these two codes are performed by a medical provider, and not part of the EPSDT well-child check-up, or by a dental provider not operating under any kind of dental supervision are they to be reported on line 12f of the CMS-416. CMS believes these services will support states in their efforts to maximize the ability of all healthcare professionals, operating within the scope of state practice acts, to serve Medicaid and CHIP enrollees. The same services performed by a dentist or under the supervision of a dentist are captured on line 12e diagnostic services.

Comment on Table 1 in CMS-416 Reporting Instructions on Language Inconsistency with Dental Instructions

One commenter noted that Table 1 to CMS-416 Reporting Instructions for Lines 12a through 12g -- Crosswalk of CPT Codes to CDT Codes -- offers introductory language for different categories of service, i.e., Diagnostic; Preventive; Periodontics, Maxillofacial Prosthetics, Implants, Oral & Maxillofacial Surgery, Adjunctive General Services, that is not always consistent with the instructions. The commenter explains the inconsistency: For Diagnostic Services, it says "...report them on lines 12f and 12g if performed by a licensed practitioner that is neither a dentist nor providing services under the supervision of a dentist, while for Preventive Services it says, "...report them on lines 12f and 12g if performed by a physician or other medical provider" and for Periodontics, Maxillofacial Prosthetics, Implants, Oral & Maxillofacial Surgery, Adjunctive General Services it says, "...report them on lines 12f and 12g if performed by a physician or other medical provider or by a dental practitioner." Some of this language conflicts with what is in the instructions.

CMS Response

We agree with this comment, and have corrected the language in the introductory language for the three categories of services in the Crosswalk of CPT codes to CDT codes.

Comment on Misspelling on Table 1 in CMS-416 Reporting Instructions

A commenter noted misspelling of the term mandibular.

CMS Response

CMS appreciates this comment and has corrected the spelling of mandibular in Table 1.