Crosswalk for Paperwork Reduction Act

Change to Instructions Only for Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report

Changes are effective on 10/1/2014 for the federal fiscal year 2015 reporting period

(No changes are made to the Form CMS-416)

Section	Type of Change	Rational for Change
B. Reporting Requirements	Expanded language on data reporting to state explicitly that data must include services reimbursed directly by the state under fee-for-service, or through managed care, prospective payment, or other payment arrangement or through any other health or dental plans that contract with the state.	While this requirement was implicit in previous instructions, the expanded language is intended to clarify and reinforce reporting requirements to report services to all eligibles, regardless of the health care setting.
C. Effective Date	Effective date of revised instructions	Change in instructions with new effective date (10/1/2014).
D. Detailed Instructions - General	Added helpful notes about reporting, including reporting data on visits based only on adjudicated, or paid, claims. Gave an example of a federal fiscal year.	Clarification of how to count individuals in the age ranges. To help states identify the exact reporting period.
D. Line 1 Total Individuals Eligible for EPSDT	Added explicit language that data must include visits reimbursed directly by the state under fee-for-service, or through managed care, prospective payment, or other payment arrangement or through any other health or dental plans that contract with the state.	While this requirement was implicit in previous instructions, the expanded language is intended to clarify and reinforce reporting requirements to report services to all eligibles, regardless of the health care setting.

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Section	Type of Change	Rational for Change
D. Line 6 Total Screens Rec'd	ICD-9 codes changed to ICD-10 codes, with each identified V diagnostic code changed to the corresponding new Z code.	Code change is required by HIPAA, effective 10/1/2014.
D. Line 11 Total Eligibles Referred for Corrective treatment	Limits the count of individuals referred for corrective action to those with a visit 90 days after an initial or periodic screen.	There is no code to capture a referral for corrective treatment. This change attempts to capture referrals by assuming that a visit occurring within 90 days of an initial or periodic screen is based on a referral for corrective treatment.
D. Dental lines Notes A and B	Explanatory notes for the dental lines are moved from the end of the dental lines instructions to the beginning of the dental lines into Note A and Note B: Note A.) Explains how to count individuals across the dental lines; Note B.) Explains the meaning of the terms "dental services" and" oral health services" for reporting purposes. A new Table 1 is identified Note B. For each dental line, the universe of appropriate procedure codes to report is provided in the instructions (HCPCS and CDT) or on the attached Table 1 (Crosswalk of CPT to CDT Codes). CPT = Current Procedural Terminology CDT = Code on Dental Procedures and Nomenclature	This additional language is intended to assist the states in understanding how to count individuals for each of the dental lines. We clarify the term, "dental services" to explain supervision ("under the supervision of a dentist") as a spectrum that includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the dental practice act. We clarify the term "oral health services" to refer to services provided by any health care practitioner working within their scope of practice and who is neither a dentist nor providing services under the supervision of a dentist, in lines 12f and 12g. Note B and the referenced Table 1 Crosswalk of CPT to CDT Codes are intended to assist states in identifying the correct CDT code for reporting dental and oral health services on the CMS-416 report.

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Section	Type of Change	Rational for Change
D. Line 12a Total Eligibles Receiving Any Dental Services	Inserts in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Refers to notes A and B and Table 1.	Clarifies how to count a child for line 12a.
D. Line 12b Total Eligibles Receiving Preventive Dental Services	Inserts in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Refers to notes A and B and Table 1.	Clarifies how to count a child for line 12b.
D. Line 12c Total Eligibles Receiving Dental Treatment Services	Inserts in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Refers to notes A and B and Table 1.	Clarifies how to count a child for line 12c.

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Section	Type of Change	Rational for Change
D. Line 12d Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	Inserts in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Refers to notes A and B. Added language to include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Added the teeth numbers for permanent molars, including third molars.	Clarifies how to count a child for line 12d. To assist states in programming data systems to capture data correctly.
D. Line 12e Total Eligibles Receiving Diagnostic Dental Services	Inserts in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Refers to notes A and B and Table 1.	Clarifies how to count a child for line 12e.

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Section	Type of Change	Rational for Change
D. Line 12f Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	Inserts in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Expands usable codes to include CPT (medical) and related CDT (dental) codes. Defines a "non-dentist provider" as any health care practitioner working within their scope of practice who is neither a dentist nor providing services under the supervision of a dentist who is neither a dentist nor providing services under the supervision of a dentist. Adds 2 new dental codes for diagnostic services that do not specify a dentist as the rendering provider, for which states can report on this line for services performed by a non-dental professional or by a dental professional not under the supervision of a dentist. These codes are: D0190 – Screening of a patient D0191 – Assessment of a patient Refers to Notes A and B.	Clarifies how to count a child for line 12f. This additional information offers states that collect this data an opportunity to demonstrate this activity on the CMS-416, and may offer an opportunity to non-dentist providers to bill the state for their services.

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Section	Type of Change	Rational for Change
D. line 12g Total Eligibles Receiving any Dental or Oral Health Service	Inserts language in each dental line, the instruction that was previously only stated in a global note, to only count individuals enrolled for at least 90 continuous days. Reminds states to only count a child once on this line, based on line 1b. Explains that an oral health service by a non-dentist is a health care practitioner working within their scope of practice who is neither a dentist nor providing services under the supervision of a dentist who is neither a dentist nor providing services under the supervision of a dentist. Refers to notes A and B.	Clarifies how to count a child for line 12g. This additional information offers states that collect this data an opportunity to demonstrate this activity on the CMS-416, and may offer an opportunity to non-dentist providers to bill the state for their services.
D. Line 13 Total Eligibles Enrolled in Managed Care	Changes language to only pull data from line 1b and removes reference to line 1a, in order to only count individuals enrolled for at least 90 continuous days. Language is edited for clarification. Some wording on the related lines is removed because it is unnecessary.	Language is edited for clarification purposes only.

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Section	Type of Change	Rational for Change
D. Line 14 Total Number of Screening Blood Test	Changes language to pull data from line 1b and removes reference to line 1a, to only count individuals enrolled for at least 90 continuous days. Added explicit language that data must include visits reimbursed directly by the state under fee-for-service, or through managed care, prospective payment, or other payment arrangement or through any other health or dental plans that contract with the state. ICD-9 codes changed to ICD-10 codes, with each identified V diagnostic code changed to the corresponding new Z code.	Clarification purposes only. This requirement was implicit in previous instructions, but language was added to clarify and reinforce reporting requirements to report services to all eligibles, regardless of the health care setting. Code change is required by HIPAA.
Table 1 Crosswalk of CPT Codes to CDT Codes for Lines 12a-12g	Crosswalk of CPT codes to CDT codes for Lines 12a – 12g of the Form CMS-416. CPT means Code on Dental Procedures and Nomenclature. These are the dental procedure codes to be used in collecting data for the CMS-416 report on the dental lines CPT means Current Procedural Terminology. These are the medical procedure codes to be used in collecting data for the CMS-416 report.	Table 1 was added to the instructions to assist states in identifying medical codes related to specific dental codes so that they can capture all allowable data for the services provided.

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Section	Type of Change	Rational for Change
	Corrected introductory language for each section under CPT codes column to conform with CMS-416 instructions. Changed the clarification of the term "oral health services" to refer to services provided by a health care practitioner working within their scope of practice and who is neither a dentist nor providing services under the supervision of a dentist, in lines 12f and 12g. Corrected misspelling of mandibular	Corrected introductory language for each section under CPT codes column to conform with CMS-416 instructions. This additional information offers states that collect this data an opportunity to demonstrate this activity on the CMS-416, and may offer an opportunity to non-dentist providers to bill the state for their services. Self-explanatory.
Table 2 Crosswalk of ICD-9 Codes to ICD-10 Codes for Line 14	Crosswalk of ICD-9 to ICD-10 Codes for Line 14 of the Form CMS-416. Line 14 captures the total number of screening blood lead tests. Added ICD-9 code 984.0 *Toxic effect of inorganic lead compounds* with crosswalk to ICD-10 code T56.0X1A *Toxic effect of lead and its compounds, accidental (unintentional), initial encounter*	Table 2 was added to the instructions to assist states in converting from ICD-9 codes to ICD-10 codes. There are many more ICD-10 codes that relate to the ICD-9 codes, so this will help states to determine the most appropriate codes for reporting purposes. To incorporate all codes that states may use for reporting purposes on the CMS-416.