Crosswalk for Paperwork Reduction Act

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

Effective for reporting period federal fiscal year 2016 (October 1, 2015 through September 30, 2016), with submission of Form CMS-416 by April 1, 2017.

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

Section	Type of Change	Rationale for Change
C. Effective Date	Effective date of revised instructions	Change in instructions with new effective date (10/1/16).
D. Detailed Instructions - General	Added helpful notes about reporting Clarify bullet to explain the data for Lines 3a – 14 (page 2), which now reads: The population for which the data is reported on Lines 3a – Line 14 are children from Line 1b, that is unduplicated counts of individuals enrolled for at least 90 continues days during the reporting period. Clarify definition/language for Categorically Needy and Medically Needy Eligibility Groups (page 2) to: Categorically Needy (CN) and Medically Needy (MN) Eligibility Groups -- For purposes of reporting data on the CMS-416, children should be reported as medically needy (with or without spend down) or categorically needy (not medically needy) based on their status as of September 30th of the reporting federal fiscal year. If they weren't enrolled in Medicaid on September 30th because their eligibility was terminated prior to that date, their status should be reported as of the date they were terminated.	Clarification of how to submit the form and format. Clarified reporting requirements bullet points Clarified the definition of Categorically Needy and Medically Needy

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D. Dental lines Notes A and B	Added to Note A (page 7): For each dental line (Lines 12a – 12g), the universe of appropriate procedure codes to report is provided in the instructions below (HCPCS or equivalent CDT or CPT codes). Added under Note B (page 7): IMPORTANT: Each dental line, Lines 12a-12g, collects information related to a type of dental service, a type of oral health service, or both. As described in Note B, this distinction relates to the type of provider who delivered the service. The instructions for each dental line specify the provider type(s) relevant to that line. It is important to pay close attention to this part of the instructions, and to report on each line only services delivered (rendered) by the type(s) of providers specified for that line. Rendering provider type can usually be discerned from the claim form. For example: a child who received a fluoride varnish treatment (D1208) from a dentist should be reported on Line 12b, preventive dental service; a child who received a fluoride varnish treatment from a physician should be reported on Line 12f, oral health service	This additional language is intended to assist the states in understanding that each dental line contains specific instructions and appropriate procedures codes to utilize. Explained that it is necessary to review the provider type to fulfill reporting.

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Section	Type of Change	Rationale for Change
D. Line 12c Total Eligibles Receiving Dental Treatment Services	Removed reference to table 1	The Table 1 reference was a carryover from a previous version and is not needed.
D. Line 14 Total Number of Screening Blood Test	Revised instructions: **Line 14 -- Total Number of Screening Blood Lead Tests --** Enter the total number of screening blood lead tests furnished to eligible individuals under the age of six from Line 1b (that is, with at least 90 continuous days of enrollment during the federal fiscal year) under fee-for-service, prospective payment, managed care, or any other payment arrangements, based on an unduplicated paid, unpaid, or denied claim. Follow-up blood tests performed on individuals who have been diagnosed with or are being treated for lead poisoning should <u>not</u> be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided: 1) Count the number of times CPT code 83655 ("lead") for a blood lead test is reported within certain ICD-10 CM codes (see Note below); or 2) You may include data collected from use of the HEDIS®[1] measure developed by the National Committee for Quality Assurance to report blood	With this change, will be asking states to identify the type of methodology used for reporting (count of CPT code, HEDIS or combination). Included additional clarifications on how to report using ICD-10 diagnosis codes. Removed reference to Z57.8 as this was an occupational code that would not be applicable.

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	lead screenings if your state had elected to use this performance measure. You should identify, when submitting your Form CMS-416 to CMS, which of these methods you used to report this data. If a combination method was used, please clarify how the sources were combined. On a claim, CPT code 83655 is the procedure code for blood lead level tests. States should report instances of CPT code 83655 which are accompanied by a diagnosis code that would indicate a person is receiving a screening blood lead test, such as a well-child check (for example Z00.121 or Z00.129), exposure to lead (Z77.011), or encounter for screening for disorder due to exposure to contaminants (Z13.88), with or without secondary codes. CPT 83655, when accompanied by a diagnosis code of T56.0X1A–4A, T56.0X1D-4D, T56.0X1S-4S or a code in the M1A.1 series would generally indicate that the person receiving the blood lead test had already been diagnosed with, or was being treated for, lead poisoning. This would not be considered a screening test. States should not report CPT codes 83655 when accompanied by a diagnosis code of T56.0X1A–4A, T56.0X1D-4D, T56.0X1S-4S or a code in the M1A.1 series.	

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Header and Footer	Updated with version and date of change to reflect Version 4, as of August 19, 2016. Removed reference in the header that stated, "Pending Implementation of ICD-10".	Provide the date for the most recent version of the instructions. ICD-10 has been implemented.
Appendix	Removed the Crosswalk of ICD-9 and ICD-10 code formatting and reference in the instructions. Deleted the Appendices.	Integrated ICD-10 codes into the instructions for Line 14 and Line 6, which removed the need to include an Appendix. Removed the Crosswalk because the migration to ICD-10 should have occurred for most states and we want to encourage the use of ICD-10 codes when possible. We can address any questions on an individual state basis.
Form CMS-416	Added Line 14b	Added Line 14b for providing more insight on the methodology used in reporting lead screening services.