Form CMS-416 Instructions Crosswalk

2017 (old version)	2020 (new version)	Type of Change	Reason for Change	Burden Change
Effective for reporting period federal fiscal year 2018 (October 1, 2017 through September 30, 2018), with submission of Form CMS-416 by April 1, 2019.	Effective for the reporting period beginning with federal fiscal year 2020 (October 1, 2019 through September 30, 2020), with submission of Form CMS-416 by April 1, 2021	Rev	Updates the federal fiscal year to which these revised instructions apply.	No

Type of Change: Rev = Revision, Del = Deletion, Add = Addition, and Red = Redesgnation.

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 29 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.	**PRA Disclosure Statement:** Annual completion of the Form CMS-416 is mandatory for states pursuant to section 1902(a)(43)(D) of the Social Security Act which requires states to annually report on the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 (expiration date June 30, 2023). The time required to complete this information collection is estimated to average 29 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.	Rev	Update to PRA disclosure statement and new placement.	No
The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services.		Rev	Provides more accurate language.	No

You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.	States may contact the state lead in their CMS office or the EPSDT technical assistance mailbox, EPSDT@cms.hhs.gov, if technical assistance is needed to complete this form.	Rev	Provides additional CMS contact information.	No
The form CMS-416's initial effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990. This version of the form is not changed from the previous version, but these associated revised instructions must be used for the reporting period federal fiscal year 2016, beginning October 1, 2015 through September 30, 2016, for data due to CMS on the form CMS-416 on or before April 1, 2017	These associated revised instructions must be used starting with the reporting period federal fiscal year 2020, beginning October 1, 2019 through September 30, 2020, for data due to CMS on the Form CMS-416 on or before April 1, 2021	Rev	Removes outdated historical information and updates the federal fiscal year to which these revised instructions apply.	No
States should submit the annual form CMS-416 and your state medical and dental periodicity schedules electronically to the CMS central office via the EPSDT mailbox at EPSDT@cms.hhs.gov not later than April 1 of the year following the end of the federal fiscal year being reported.	States should submit the annual Form CMS-416 and the state medical and dental periodicity schedules electronically to the CMS central office via the EPSDT technical assistance mailbox at EPSDT@cms.hhs.gov not later than April 1 of the year following the end of the federal fiscal year being reported.	Rev	Provides grammatical changes and provides the revised name of the mailbox.	No
http://www.medicaid.gov/Medicaid-CHIP-P	https://www.medicaid.gov/medicaid/benefi	Rev	Provides the correct URL on Medicaid.gov where the form and instructions can be found.	No

States that have data limitations or that have made program changes during a reporting period that significantly impact data results, such as a change in the periodicity schedule to follow the most recent version of the American Academy of Pediatrics' Bright Futures™ guidelines, may include a note, not to exceed 50 words, with the cover correspondence accompanying their CMS-416 submissions. This information will be included in a separate footnotes page on the Medicaid.gov website, accompanying the national and state data reports.	States that have data limitations or that have made program changes during a reporting period that significantly impact data results, such as a change in the periodicity schedule to follow the most recent version of the American Academy of Pediatrics' Bright Futures™ guidelines, may include a brief note with the cover correspondence accompanying their CMS-416 submission. This information will be included in a separate footnotes document on the Medicaid.gov website, accompanying the national and state data reports.	Rev	Removes a word count limit for the length of the text that states can submit as a footnote, and clarifies that the footnotes are presented in a separate document vs. a separate page.	No
State -- Enter the name of your state using the two character state code in upper case format.	State -- Enter the name of your state using the two character state code in upper case format.	Rev	Language did not change, but the location of the text was moved due to the new state option to have CMS generate the Form CMS-416.	No
Note: The federal fiscal year is from October 1 through September 30. For example, FFY 2017 is October 1, 2016 through September 30, 2017	Note: The federal fiscal year is from October 1 through September 30. For example, FFY 2020 is October 1, 2019 through September 30, 2020	Rev	Updates the federal fiscal year provided in the example. The location of the text was moved due to the new state option to have CMS generate the Form CMS-416.	No

	CMS Generated Reporting of State Form CMS-416 Using T-MSIS -- In an effort to reduce state reporting burden, CMS has developed the capacity to generate state-specific Form CMS-416 reports using state-reported data to CMS via the Transformed Medicaid Statistical Information System (T-MSIS). This option is available only to states that are current with T-MSIS data submissions and pass T-MSIS benchmarks for data quality and completeness. If your state gives CMS permission to generate Form CMS-416 data using T-MSIS, please enter an "X" in the space provided on the form, along with the two digit state code and the federal fiscal year. The rest of the form should remain blank. The form and copies of the state's current medical and dental periodicity schedules should be submitted to CMS by April 1st via the EPSDT technical assistance mailbox. States that select this option will be given an opportunity to review and validate the T-MSIS generated report before it is finalized and made publicly available. States that choose not to have CMS generate the state-specific Form CMS-416 or who do not meet the criteria to have CMS generate the Form CMS-416 should follow the detailed instructions for the completion of the Form CMS-416.	Add	Provides a new option for states that are current with T-MSIS data submissions and pass T-MSIS benchmarks for data quality and completeness to allow CMS to generate the data on their behalf using information states already submit through T-MSIS. The completed forms will be provided to states to review and validate the T-MSIS generated report. This change is intended to reduce the reporting burden for states.	Yes--reduces the burden of reporting by allowing states the option for CMS to report the data on their behalf.
For each of the following line items, report total counts by the age groups indicated and by whether categorically or medically needy (described below).	For each of the following line items, report total counts by the age groups indicated and if categorically or medically needy (described below).	Rev	Corrects grammar.	No
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.	For example, if a child turned age 3 on September 1st, but received EPSDT services at age 2, these services would be counted in the age 3-5 category.	Rev	Clarifies the example so that it is viewed as being broadly applicable to reporting across the form.	No

	Do not enter any data into the dark or light greyed-out cells.	Add	Clarifies that states should not attempt to report data in greyed out cells.	No
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.	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 eligibility 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 this date, their status should be reported as of the date they were terminated. States should determine the basis of eligibility consistent with the instructions from the T-MSIS Data Dictionary, in consultation with state Medicaid eligibility officials, if needed.	Rev	Clarifies that status in this sentence is referring to eligibility status. Moves text reflecting the T-MSIS Data Dictionary to this section from a later section, as the language is more appropriate in this section.	No
Line 1a -- Total Individuals Eligible for EPSDT -- Enter the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children's Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age and by basis of eligibility as of September 30.	Line 1a -- Total Individuals Eligible for EPSDT -- Enter the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children's Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age and by basis of eligibility (i.e., CN or MN) as of September 30.	Rev	Clarifies that basis of eligibility is referring to categorically needy or medically needy.	No
	If a child was not enrolled in Medicaid on September 30th because their eligibility was terminated prior to this date, the child should still be included on this line. Their age should be reported as of September 30th of the reporting year, while their basis of eligibility should be reported as of the date they were terminated.	Add	Provides an example of how to report by basis of eligibility and age.	No

States should determine the basis of eligibility consistent with the instructions from the Transformed Medicaid Statistical Information System (T-MSIS) Data Dictionary, in consultation with state Medicaid eligibility officials, if needed. 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.		Rev	This text was moved up to the Categorically Needy (CN) and Medically Need (MN) Eligibility Groups section.	No
(Example: If your state's periodicity schedule requires screening at 12, 15, 18 and 24 months, the number 4 should be entered in the 1-2 age group column.)	(Example: If your state's periodicity schedule requires screening at 12, 15, 18, 24, and 30 months, the number 5 should be entered in the 1-2 age group column.)	Rev	To clarify that the 30-month visit should be included in the 1-2 age group.	No
	If your state follows the 2019 American Academy of Pediatrics' Bright Futures™ guidelines, the periodicity schedule should be reported on the form as follows: Age Group <1 Age Group - 7 screenings 1-2 Ag e Group - 5 screenings 3-5 Age Group - 3 screenings 6-9 Age Group - 4 screenings 10-14 Age Group - 5 screenings 15-18 Age Group - 4 screenings 19 -20 Age Group - 2	Add	Provides guidance about how to report the Bright Futures guidelines on the form, as many states follow Bright Future but not all states include the newborn visit in the <1 age group. Note: In the instructions, this information will be included in the format of a table.	No
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 2c -- Annualized State Periodicity Schedule -- Make no entries on this line. This line is auto-calculated by dividing the values on Line 2a by the numbers on Line 2b. This is the number of screenings expected to be received by an individual in each age group in one year.	Rev	Clarifies that states should not report data on this line as it is auto-calculated using values states reported on other lines of the form. This is in alignment with new text added to the instructions that clarifies that states should not report data in greyed out cells.	No

Line 3b -- Average Period of Eligibility -- Divide Line 3a by the number in Line 1b. Divide that number by 12 and enter the quotient. This number represents the portion of the year that individuals remained eligible for EPSDT services during the reporting year.	Line 3b -- Average Period of Eligibility -- Make no entries on this line. This line is auto-calculated by dividing the values on Line 3a by the numbers on Line 1b, and dividing that number by 12. This number represents the portion of the year that individuals remained eligible for EPSDT services during the reporting year.	Rev	Clarifies that states should not enter data on this line as it is auto-calculated using values states reported on other lines of the form. This is in alignment with new text added to the instructions that clarifies that states should not report data in greyed out cells.	No
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 individual under age 21 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 4 -- Expected Number of Screenings per Eligible -- Make no entries on this line. This line is auto-calculated by multiplying Line 2c by Line 3b. This number reflects the expected number of initial or periodic screenings per individual under age 21 per year based on the number required by the state-specific periodicity schedule and the average period of eligibility.	Rev	Clarifies that states should not report data on this line as it is auto-calculated using values states reported on other lines of the form. This is in alignment with new text added to the instructions that clarifies that states should not report data in greyed out cells.	No
Line 5 -- Expected Number of Screenings -- Multiply Line 4 by Line 1b. Enter the product. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1b.	Line 5 -- Expected Number of Screenings -- Make no entries on this line. This line is auto-calculated by multiplying Line 4 by Line 1b. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1b.	Rev	Clarifies that states should not report data on this line as it is auto-calculated using values states reported on other lines of the form. This is in alignment with new text added to the instructions that clarifies that states should not report data in greyed out cells.	
and, and/or		Rev	Removes superfluous text attached to the code set for Line 6.	No
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 received the number of initial and periodic screening services required by the state's periodicity schedule, prorated by the proportion of the year for which they were EPSDT eligible. Note: In calculating Line 7, if the number exceeds 100 percent, enter 1.0 in this field.	Line 7 -- Screening Ratio -- Make no entries on this line. This line is auto-calculated by dividing 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 received the number of initial and periodic screening services required by the state's periodicity schedule, prorated by the proportion of the year for which they were EPSDT eligible.	Rev	Clarifies that states should not enter data on this line since it is auto-calculated. Also removes the note directing states to enter 1.0 if the number exceeds 100 percent. That instruction is no longer necessary as this line is auto-calculated.	No

Line 8 -- Total Eligibles Who Should Receive at Least One Initial or Periodic Screen -- The number of individuals 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 on 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 on Line 1b of the form. Enter the product on Line 8.	Line 8 -- Total Eligibles Who Should Receive at Least One Initial or Periodic Screen -- Make no entries on this line. This line is auto-calculated by multiplying Line 4 by Line 1b. Note: If the number on Line 4 is greater than 1, the number 1 will be used. (This will eliminate situations where more than one visit is expected in any age group in a year.) This reflects the number of individuals who should receive at least one initial or periodic screen, based on the state's periodicity schedule.	Rev	Clarifies that states should not enter data on this line as it is auto-calculated using values states reported on other lines of the form. This is in alignment with new text added to the instructions that clarifies that states should not report data in greyed out cells.	No
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, if this number exceeds 100 percent, enter 1.0 in this field.	Line 10 -- Participant Ratio -- Make no entries on this line. This line is auto-calculated by dividing Line 9 by Line 8. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.	Rev	Clarifies that states should not enter data on this line since it is auto-calculated. This is in alignment with new text added to the instructions that clarifies that states should not attempt to report data in greyed out cells. Also removes the note regarding value over 100 percent as that instruction is no longer necessary as this line is auto-calculated	No
Dental Lines 12a – 12g	Dental and Oral Health Lines 12a – 12g	Rev	Clarifies that reporting on Lines 12a-12g includes both dental and oral health.	No
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).	For each dental or oral health 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).	Rev	Clarifies that reporting on Lines 12a-12g includes both dental and oral health.	No
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.	NOTE C: Each dental or oral health 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 or oral health line specify the provider type(s) relevant to that line.	Rev	Changes 'Important' to 'Note C," and clarifies that reporting on Lines 12a-12g includes both dental and oral health.	No

	Both children should be reported on Line 12g, preventive dental or oral health service.	Add	Provides an example that children with preventive dental and oral health services should be reported on Line 12g, which has been revised to capture only preventive services.	No
Line 12a -- Total Eligibles Receiving Any 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 dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999 or equivalent CPT codes), based on an unduplicated paid, unpaid, or denied claim. All individuals reported on Lines 12b through 12e should be reported on this line, though an individual should be counted only once on this line regardless of how many dental services he or she received during the reporting period. See Notes A and B, above.	Line 12a -- Total Eligibles Receiving Any 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 dental service by or under the supervision of a dentist. These services are defined by HCPCS codes D0100 – D9999 (or equivalent CDT codes D0100 – D9999), or equivalent CPT codes, based on an unduplicated paid, unpaid, or denied claim. All individuals reported on Lines 12b through 12e should be reported on this line, though an individual should be counted only once on this line regardless of how many dental services he or she received during the reporting period. See Notes A, B, and C, above.	Rev	Revises the instructions for this line to provide clarity on the codes that should be used. Also updates the reference to the Notes to include Note C.	No
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 equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim. See Notes A and B, above.	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. These services are defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 – D1999), or equivalent CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A, B, and C above.	Rev	Revises the instructions for this line to provide clarity on the codes that should be used. Also updates the reference to the Notes to include Note C.	No

Line 12c -- Total Eligibles Receiving Dental Treatment 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 dental treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (or equivalent CDT codes D2000 – D9999 or equivalent CPT codes (please refer to the CPT-to-CDT crosswalk available on Medicaid.gov) that include only those CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A and B, above.	Line 12c -- Total Eligibles Receiving Dental Treatment 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 dental treatment service by or under the supervision of a dentist. These services are defined by HCPCS codes D2000 – D9999 (or equivalent CDT codes D2000 – D9999), or equivalent CPT codes that include only those that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A, B, and C, above.	Rev	Revises the instructions for this line to provide clarity on the codes that should be used. Also updates the reference to the Notes to include Note C.	No
Line 12d -- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of individuals with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b, in the appropriate age categories of 6-9 and 10-14, who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32. See Notes A and B, above.	Line 12d -- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of individuals with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b, in the appropriate age categories of 6-9 and 10-14, who received a sealant on a permanent molar tooth. Sealants are defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32. See Notes A, B, and C, above.	Rev	Revises the instructions for this line to provide clarity. Also updates the reference to the Notes to include Note C.	No

Line 12e -- Total Eligibles Receiving Diagnostic 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 diagnostic dental service by or under the supervision of a dentist, as defined by HCPCS codes D0100-D0999 (or equivalentCDT codes D0100 –D0999 or equivalent CPT codes, that is, only those CPT codes that are for diagnostic dental services, and only if provided by or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A and B, above.	Line 12e -- Total Eligibles Receiving Diagnostic 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 diagnostic dental service by or under the supervision of a dentist. These services are defined by HCPCS codes D0100 – D0999 (or equivalent CDT codes D0100 – D0999), or equivalent CPT codes that are for diagnostic dental services, and only if provided by or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A, B, and C, above.	Rev	Revises the instructions for this line to break up previously lengthy run-on sentences into separate sentences for clarity.	No
12f -- Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider -- 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 oral health service, as defined by HCPCS or CDT codes, or equivalent CPT codes, that is, only those CPT codes that are for oral health services, and only if provided by a non-dentist provider, based on an unduplicated paid, unpaid, or denied claim. A “non-dentist provider” is any qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist. NOTE: Due to the variance in state practice acts and reimbursement policies, some states may not have data to report on this line. See Notes A and B, above.	12f -- Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider -- 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 oral health service by a non-dentist provider. These services are defined by HCPCS codes D0100 – D9999 (or equivalent CDT codes D0100 – D9999), or equivalent CPT codes that are for oral health services, and only if provided by a non-dentist provider, based on an unduplicated paid, unpaid, or denied claim. A “non-dentist provider” is any qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist. NOTE: Due to the variance in state practice acts and reimbursement policies, some states may not have data to report on this line. See Notes A, B, and C, above.	Rev	Adds the range of codes that states should use to report data on Line 12f, in alignment with the instructions for other dental and oral health lines on the report. Revises instruction for clarity and updates the reference to the Notes to include Note C.	No

12g -- Total Eligibles Receiving any Dental or Oral Health Service -- 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 either a “dental service” by or under the supervision of a dentist or an “oral health service” by a qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. All individuals reported in Lines 12a through 12f should also be reported on this line, though an individual should be counted only once on this line regardless of how many dental services and oral health services he or she received during the reporting period, that is, no matter how many times they appear in lines 12a through 12f. See Notes A and B, above.	12g -- Total Eligibles Receiving any Preventive Dental or Oral Health Service -- 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 either a preventive “dental service” by or under the supervision of a dentist or a preventive “oral health service” by a qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist. These services are defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 – D1999), or equivalent CPT codes that are for preventive dental or oral health services, based on an unduplicated paid, unpaid, or denied claim. All individuals reported on Line 12b, as well as only those individuals from Line 12f who received preventive services, should also be reported on this line. While some individuals may appear on both Lines 12b and 12f , an individual should be counted only once on this line regardless of how many preventive dental services and/or preventive oral health services he or she received during the reporting period. See Notes A, B, and C, above.	Rev	Changes the instructions for Line 12g to collect data only on children's receipt of preventive dental and oral health services vs. any dental or oral health services. This change will allow CMS to more fully capture the providers and settings where preventive oral health services are being delivered. Also adds the range of codes that states should use to report data on this line, in alignment with the instructions for the other dental and oral health lines of the report.	No
Line 14 - Total Number of Screening Blood Lead Tests	Line 14a - Total Number of Screening Blood Lead Tests	Rev	Updates the instructions to match the Form CMS-416.	No
When responding to the question on the Form CMS-416, “Which methodology was used for calculating the total number of screening blood lead tests on Line 14,” you should identify the methodology used by your state for the calculation:	Line 14b -- Methodology Used to Calculate the Total Number of Blood Lead Tests -- Identify the methodology used by your state to calculate the number of blood lead tests furnished to the children reported on Line 14a by entering an “X” on the form next to the methodology used:	Rev	Revises the instructions to reflect Line 14b on the Form CMS-416. Also revises the language for clarity.	No