2024 (old version)	2025 (new version)	Type of Change	Reason for Change	Burden Change
Effective for the reporting period beginning with federal fiscal year 2023 (October 1, 2022 through September 30, 2023), with submission of Form CMS-416 by April 1, 2024	Effective for the reporting period federal fiscal year 2026 (October 1, 2025 through September 30, 2026), with submission of Form CMS-416 by April 1, 2027.	Rev	Updates the federal fiscal year to which these revised instructions apply.	No
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 July 31, 2026). 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.	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 July 31, 2029). The time required to complete this information collection is estimated to average 28.5 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	Updates the disclosure statement to reflect proposed new expiration date and the estimated average number of hours for completion.	No
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 the form.	States may contact their CMS state lead or the EPSDT technical assistance mailbox, EPSDT@cms.hhs.gov, if technical assistance is needed to complete the form.	Rev	Minor edit to reflect current CMS organizational structure.	No

C. Effective Date –These associated revised instructions must be used starting with the reporting period federal fiscal year 2023, beginning October 1, 2022 through September 30, 2023, for data due to CMS on the Form CMS-416 on or before April 1, 2024.	C. Effective Date –These associated revised instructions must be used starting with the reporting period federal fiscal year 2026, beginning October 1, 2025 through September 30, 2026, for data due to CMS on the Form CMS-416 on or before April 1, 2027.	Rev	Updates the federal fiscal year to which these revised instructions apply.	No
Fiscal Year -- Enter the federal fiscal year (FFY) being reported in YYYY format. Note: The federal fiscal year is from October 1 through September 30. For example, FFY 2023 is October 1, 2022 through September 30, 2023	Fiscal Year -- Enter the federal fiscal year (FFY) being reported in YYYY format. Note: The federal fiscal year is from October 1 through September 30. For example, FFY 2026 is October 1, 2025 through September 30, 2026.	Rev	Updates the federal fiscal year provided in the example.	No
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	States that choose not to have CMS generate their state-specific Form CMS-416 or that 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	Rev	Made minor grammatical edits to the language.	No
The population for which the data is reported on Lines 3a –14 are children from Line 1b, that is unduplicated counts of individuals enrolled for at least 90 continuous days during the reporting period	The population for which the data are reported on Lines 3a –14 is children from Line 1b—that is, unduplicated counts of individuals enrolled for at least 90 continuous days during the reporting period	Rev	Made minor grammatical edits to the language.	No
	Count the number of unique screens that occurred using unique dates of service (rather than counting claims that indicate a screen). This will avoid the potential for duplicate counting of services with multiple claims.	Addition	Provides guidance to states about how to report screening data across the form.	Yes. Increases burden for states to make the appropriate coding changes to report the data according to this guidance where they are not doing so currently.
If your state follows the 2019 American Academy of Pediatrics' Bright Futures™ guidelines, the periodicity schedule should be reported on the form as follows:	If your state follows the 2025 American Academy of Pediatrics' Bright Futures™ guidelines, the periodicity schedule should be reported on the form as follows:	Rev	Updates the date to the most current version of the Bright Futures guidelines.	No

CPT-4 codes: Evaluation and Management Codes ** 99202-99205 New Patient 99213-99215 Established Patient ** These CPT-4 codes must be used in conjunction with the following Z codes:	Evaluation and Management Codes/Clinic Visit Codes ** 99202-99205 New Patient 99213-99215 Established Patient T1015 All-Inclusive Clinic Visit/Encounter ** These codes must be used in conjunction with the following Z codes:	Addition	Adds a code to the instructions for this line that many states already use to report children's receipt of initial and periodic screenings. Deleted references to CPT-4 codes as the new code is a HCPCS code.	Yes. Increases burden for states to make the appropriate coding changes to report the data according to these new specifications.
Line 9 -- Total Eligibles Receiving at Least One Initial or Periodic Screen -- Enter the unduplicated number of individuals under age 21 with at least 90 days continuous enrollment within the federal fiscal year from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who received at least one documented initial or periodic screen during the year, based on an unduplicated paid, unpaid, or denied claim. Refer to codes in Line 6.	Line 9 -- Total Eligibles Receiving at Least One Initial or Periodic Screen -- Enter the unduplicated number of individuals from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who received at least one documented initial or periodic screen during the year, based on an unduplicated paid, unpaid, or denied claim. Refer to codes in Line 6.	Rev	Removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	No
NOTE B: “Dental services” refers to services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state’s dental practice act. The most common examples of this are dentists themselves, and dental hygienists who are working under the supervision of dentists. “Oral health services” refers to services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. The most common examples of this are primary care medical providers and dental hygienists or dental therapists who are not working under the supervision of a dentist.	NOTE B: “Dental services” refers to services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state’s dental practice act. The most common examples of this are dentists themselves, and dental hygienists who are working under the supervision of dentists. “Oral health services” refers to services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. The most common examples of this are primary care medical providers and dental hygienists or dental therapists who are not working under the supervision of a dentist. The Dental Quality Alliance maintains a value set of taxonomy codes to identify dental services that the state may use as a resource for classifying providers.	Addition	Adds language to provide a resource that states can use to classify dental service providers.	Yes. Increases burden for states to make the appropriate coding changes to report the data according to this guidance where they are not doing so currently.

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.	Line 12a -- Total Eligibles Receiving Any Dental Services -- Enter the unduplicated number of individuals 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	Removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	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. 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.	Line 12b -- Total Eligibles Receiving Preventive Dental Services -- Enter the unduplicated number of individuals 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.		Removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	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. 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.	Line 12c -- Total Eligibles Receiving Dental Treatment Services -- Enter the unduplicated number of individuals 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.		Removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	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. 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.	Line 12d -- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of individuals 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.		Removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	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. 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.	Line 12e -- Total Eligibles Receiving Diagnostic Dental Services -- Enter the unduplicated number of individuals 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.		Removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	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 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.	12f -- Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider -- Enter the unduplicated number of individuals 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 CPT code 99188 (or other equivalent CPT codes specifically identified by the state) 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. CMS recognizes that some states allow oral health assessments to be conducted by physicians as part of office visits and documented with the modifier 'DA'. These oral health assessments are appropriate for inclusion in Line 12f but should not be counted for any other Line 12 measures.	Rev	Adds language to provide states with additional coding guidance about how to report dental or oral health services. Also removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	Yes. Increases burden for states to make the appropriate coding changes to report the data according to these new specifications where they are not doing so currently.

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.	12g -- Total Eligibles Receiving any Preventive Dental or Oral Health Service -- Enter the unduplicated number of individuals 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 CPT code 99188 (or other equivalent CPT codes specifically identified by the state) 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	Adds language to provide states with additional coding guidance about how to report dental or oral health services. Also removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	Yes. Increases burden for states to make the appropriate coding changes to report the data according to these new specifications where they are not doing so currently.
Line 13 -- Total Eligibles Enrolled in Managed Care -- This number is reported for informational purposes only. Enter the total unduplicated number of individuals from Line 1b who are enrolled in any type of managed care arrangement, whether medical or dental or both, at any time during the reporting year. This includes any capitated arrangements such as managed care entities or individuals assigned to a primary care provider or primary care case manager, regardless of whether reimbursement to the provider is fee-for-service or capitated.	Line 13 -- Total Eligibles Enrolled in Managed Care -- This number is reported for informational purposes only. Enter the total unduplicated number of individuals from Line 1b who were enrolled in any type of managed care arrangement, whether medical or dental or both, at any time during the reporting year. This includes any capitated arrangements such as managed care entities or individuals assigned to a primary care provider or primary care case manager, regardless of whether reimbursement to the provider is fee-for-service or capitated.	Rev	Made minor grammatical edits to the language.	No.

Line 14a -- 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 not 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 lead screenings if your state has elected to use this performance measure.	Line 14a -- Total Eligibles Receiving Blood Lead Screenings -- Enter the unduplicated number of individuals under the age of six from Line 1b who received at least one blood lead screening. 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 unduplicated number of eligibles for whom CPT code 83655 (“lead”) for a blood lead screening was reported; 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 lead screenings if your state has elected to use this performance measure.	Rev	Revises the methodology to capture the total number of eligibles who received blood lead screening tests versus a count of screenings to bring this line into alignment with other reporting lines and allow CMS to more easily calculate the rate of individuals with blood lead screenings.	Yes. Reduces burden for states due to simplification of the specifications.

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: 1) CPT Code 83655 within certain diagnoses codes (Method I) 2) HEDIS (Method II) 3) Combination Methodology (Method III) 1 Health Effectiveness Data and Information Set NOTE: 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.	Line 14b -- Methodology Used to Calculate the Total Eligibles Receiving Blood Lead Screenings -- Identify the methodology used by your state to calculate the unduplicated number of individuals reported on Line 14a who received at least one blood lead screening by entering an “X” on the form next to the methodology used: 1) CPT Code 83655 (Method I) 2) HEDIS (Method II) 3) Combination Methodology (Method III) 1 Health Effectiveness Data and Information Set	Rev	Revises the methodology to capture the total number of eligibles who received blood lead screening tests versus a count of screenings, to bring this line into alignment with other reporting lines and allow CMS to more easily calculate the rate of individuals with blood lead screenings. Also removes examples of inclusionary and exclusionary diagnosis codes because these examples are incomplete and may result in inconsistency in reporting across states and potential undercounting of screenings. Additionally, removes text to ensure a parallel structure to the language throughout the instructions for each line, and remove duplicative language.	Yes. Reduces burden for states due to simplification of the specifications.

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