**EPSDT Screening Codes and Methodology**
**01/2014**

## DESCRIPTION OF CMS-416 REPORT

When compiling data for the CMS-416 report, participants must have been Medicaid eligible during the reporting federal fiscal year and claims must have had a first or last date of service within that year. Participant age is based on September 30 of the reporting federal fiscal year and only those participants under the age of 21 are included. Participants and claims with the following ME codes are excluded from the report: 02, 08, 52, 57, 58, 59, 64, and 80 and 89.

A LINE-BY-LINE DESCRIPTION OF THE CMS-416 REPORT FOLLOWS:

1A) Total Individuals Eligible for EPSDT – Total number of unduplicated EPSDT eligibles. 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 (based on age as of September 30) and by basis of eligibility. "Unduplicated" means that an eligible person is reported only once although he/she may have had more than one period of eligibility during the year. Include all individuals regardless of whether the services are provided under fee-for-service arrangements or managed care arrangements.

1B) **Total Individuals Eligible for EPSDT for 90 Continuous Days** -- Enter the total unduplicated number of individuals under the age of 21 from line 1a who have been continuously enrolled in Medicaid for at least 90 days in the federal fiscal year.

1C) **Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion Program** – Enter the number of individuals **included in line 1b** who are under the age of 21 and eligible for EPSDT services as part of a CHIP Medicaid expansion program, ME codes 71 and 72. For children who have been eligible for EPSDT under both Medicaid and a CHIP Medicaid expansion program during the report year, include the child on this line if they are enrolled in CHIP as of September 30.

2A) State Periodicity –

| Age Group: | <1 | 1-2 | 3-5 | 6-9 | 10-14 | 15-18 | 19-20 |
|---|---|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 3 | 2 | 1 |

2B) Number of Years in Age Group – Fixed Number

| Age Group: | <1 | 1-2 | 3-5 | 6-9 | 10-14 | 15-18 | 19-20 |
|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 4 | 2 |

2C) Annualized State Periodicity Schedule – Line 2A divided by line 2B

3A) Total Months of Eligibility – Total number of Medicaid eligible months for the participants included in line 1b. (Note: To calculate the number of months for each individual, the eligibility start date is subtracted from the eligibility stop date. The result is returned as a number of months along with the remaining number of days. If the number of remaining days is greater than 15, the participant is considered to be eligible for an extra month. Prior to doing the calculation, the eligibility start and stop dates are compared to the beginning and ending dates of the FFY. If the

eligibility start date is prior to the FFY begin date, it is modified to equal the FFY begin date. If the eligibility stop date is after the FFY end date; it is modified to equal the FFY end date. )

3B) Average Period of Eligibility – Line 3A divided by line 1b then divided by 12

4) Expected Number of Screenings per Eligible – Line 2C multiplied by line 3B

5) Expected Number of Screenings – Line 4 multiplied by line 1b.

6) Total screens received – Number of claims, for EPSDT eligible participants on line 1b, having one of the following Procedure Codes: 99381-99385, 99391-99395, 99460, 99461, 99463, 59400, 59510, 59610, 59618, 99222, 99223, 99295, 99435, 99244 , 99245, 99254, 99255. Procedure codes 99201-99205 or 99211-99215 with a diagnosis code of V20-V20.2, V20.3, V20.31, V20.32 and/or V70.00 and/or V70.3-V70.9. Also included in this count are professional claims with a provider type 59 and an EPSDT ind = Y and inpatient claims with a provider type 59 and a condition code A1.

   Report all screening data in the age category reflecting the child's age at the end of the federal fiscal year even if the child received services in two age categories. 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.

7) Screening Ratio – Divide line 6 by line 5. If this number exceeds 100%, 1.0 will be reflected on the report.

8) Total Eligibles Who Should Receive at Least One Initial or Periodic Screen – 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 in line 1b of the form. Enter the product on line 8.

9) Total Eligibles Receiving at Least One Initial or Periodic Screen – Unduplicated number of EPSDT eligible participants from line 1b receiving at least one screen during the reporting year. The same procedure codes are used as in line 6.

10) Participant Ratio – Divide line 9 by line 8.

11) Total Eligibles Referred for Corrective Treatment – Unduplicated number of EPSDT eligible participants on line 1b having at least one screen with a procedure code of 59400, 59510, 59610, 59618, 99222, 99223, 99244, 99245, 99254, 99255, 99295, 99201 – 99205, 99211 – 99215, 99241 – 99245, 99251 – 99255, 99221, , 92002, 92004, 92012, 92014, 92015, 92018, 92019, 92020, 92060, 92065, 92070, 92081, 92082, 92083, 92100, 92506, or 92508 **AFTER** having an EPSDT screening service as defined in Line 6 above.

12A) Total Eligibles Receiving Any Dental Services – Unduplicated number of EPSDT eligible participants having at least one dental service with a Claim Type = 'L', or a medical claim with 40 provider type as performing or billing.

12B) Total Eligibles Receiving Preventive Dental Services – Unduplicated number of EPSDT eligible participants having at least one preventive dental service with:

A. a Claim Type = 'L', or a medical claim with a 40 provider type as billing or performing; **and**
B. a procedure code of D1000-D1999, 01000-01999, 99201-99215, and 99249 during the reporting year.

12C) Total Eligibles Receiving Dental Treatment Services – Unduplicated number of EPSDT eligible participants having at least one dental treatment service with:

A. a Claim Type = 'L', or a medical claim with a 40 provider type as billing or performing; **and**
B. a procedure code of D2000-D9999, 02000-09999, 99221-99233, 99241-99263, 99050, 99058, 99281-99285, 10000-69979 during the reporting year

12D) Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of children in the age categories of 6-9 and 10-14 who received a sealant on a permanent molar tooth regardless of whether the sealant was provided by a dentist or a non-dentist, as defined by HCPCS code D1351 on a medical claim type or claim type L.

12E) Total Eligibles Receiving Diagnostic Dental Services – Enter the unduplicated number of children receiving at least one diagnostic dental service by or under the supervision of a dentist, with:

A. Claim Type = 'L', or a medical claim with a 40 provider type as billing or performing; **and**
B. HCPCS codes D0120 – D0180 (CDT codes D0120 – D0180).

12F) Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider -- Enter the unduplicated number of children receiving at least one oral health service as defined a HCPCS or CDT code furnished by a licensed practitioner that is not a dentist. For example, a pediatrician that applies a fluoride varnish or an independently practicing dental hygienist not under the supervision of a dentist furnishing a prophylaxis.

Claim type not L; and
Claim provider type is not 40; and
Procedure Code is D0100 – D9999

12G) Total Eligibles Receiving any Dental or Oral Health Service -- Enter the unduplicated number of children who received a dental service by or under the supervision of a dentist or an oral health service by a non-dentist. A child should only be counted **once** on this line even if the child received a dental service and an oral health service. Claim count criteria should include any claim with the procedure code D0100-D9999.

NOTES FOR LINE 12 DATA: For purposes of reporting the information on dental services in Lines 12a – 12g, use the total eligible individuals from line 1b. "Unduplicated" means that a child may only be counted once for each line of data. A child may be counted on two or more lines. For example, a child is counted once on line 12a for receiving any dental service, counted again on line 12c for receiving a dental treatment service and, if applicable, counted again on line 12f for receiving an oral health service by a non-dentist. These numbers should reflect services provided

under both fee-for-service and managed care arrangements and through any other private health plans that contract with the State.

13) Total Eligibles Enrolled in Managed Care – Number of EPSDT eligibles who were enrolled with a health plan at some time during the reporting year. Include these individuals in the total number of eligibles on line 1a and b, as appropriate; include the number of initial or periodic screenings provided to these individuals in lines 6 and 8 for purposes of determining the State's screening and participation rates. The number of individuals referred for corrective treatment and receiving dental services are reflected in lines 11 and 12, respectively.

14) Total Number of Screening Blood Lead Tests – Number of claims, for EPSDT eligible participants from line 1a, having a procedure code of 83655 with a diagnosis code other than 984.0-984.9 and E861.5 and E866.0