

2700.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

A. Purpose -- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

The completed report demonstrates the state's attainment of its participation and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on the form CMS-416. From the completed reports, trend patterns and projections are developed for the nation and for individual states or geographic areas, from which decision and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirement -- Each state that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date -- The form CMS-416 effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990.

D. **Electronic Submittal Procedure -- Submit your annual CMS-416 and your state periodicity schedule electronically to the CMS by using the interactive Excel spreadsheet provided to you. The report should be sent to the EPSDT mailbox at: EPSDT@cms.hhs.gov. A "hard copy" submittal to CMS is no longer required.**

The report should be submitted no later than April 1 of the year following the end of the Federal fiscal year being reported. You may submit a cover letter transmitting your data by attaching the file to the electronic form submission along with your periodicity schedule.

E. Detailed Instructions – **It is no longer necessary for you to enter each line of data. The interactive Excel spreadsheet will calculate many of the lines of data. You will only be allowed to enter data on the lines specified. Areas that are shaded denote pre-calculated fields that do not require you to make an entry. Make no entry in the Total column. This is a calculated field.**

State: Enter the name of your state. (Two letter State abbreviation)

Fiscal Year: Enter the Federal fiscal year being reported. (Use the following format: YYYY)

For each of the following line items, report counts by the age groups indicated and by whether categorically and medically needy. **Report age based upon the child's age as of September 30.**

Line 1 -- Total Individuals Eligible for EPSDT

- **ENTER** the total unduplicated number of all individuals under the age of 21 determined to be eligible for EPSDT services, distributed by age and by basis of Medicaid 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 or managed care arrangements. States should determine basis of eligibility consistent with the instructions for form CMS-2082. 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. Individuals for whom third-party liability is available should also be counted in the number.

Note: Do not include in this count the following groups of individuals:

- 1) medically needy individuals under the age of 21 if you do not provide EPSDT services for the medically needy population;
- 2) individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available;
- 3) undocumented aliens who are eligible only for emergency Medicaid services; or
- 4) other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

Line 2a - State Periodicity Schedule –

- **ENTER** the number of initial or periodic general health screenings required to be provided to individuals within the age group specified according to the State’s periodicity schedule. (Example: If your State periodicity schedule requires screening at 12, 18 and 24 months, the number 3 should be entered in the 1-2 age group column.)

Note 1: Use the state’s most recent periodicity schedule and attach a copy to the completed report for submittal to CMS.

Line 2b - Number of Years in Age Group -- **Make no entries on this line.** This is a fixed number reflecting the number of years included in each age group.

Line 2c - Annualized State Periodicity Schedule -- **Make no entries on this line.** This is a fixed number which divides line 2a by the number in line 2b. 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 3a - Total Months of Eligibility –

- Enter the total months of eligibility for the individuals in each age group in line 1 during the reporting year.

Line 3b - Average Period of Eligibility -- **Make no entries on this line.** This is a fixed number which divides line 3a by the number in line 1. This number represents the portion of the year

that individuals remain Medicaid eligible during the reporting year, regardless of whether eligibility was maintained continuously.

Line 4 - Expected Number of Screenings per Eligible -- Make no entries on this line. This is a fixed number which multiplies line 2c by line 3b. This number reflects the expected number of initial or periodic screenings per child 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 5 - Expected Number of Screenings -- Make no entries on this line. This is a fixed number which multiplies line 4 by line 1. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1.

Line 6 - Total Screens Received –

- **ENTER** the total number of initial or periodic screens furnished to eligible individuals under either fee-for-service or managed care arrangements.

NOTE: Use the CPT codes listed below or any State-specific EPSDT codes you may have developed in your state as a proxy for reporting these screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients.

This number should not reflect sick visits or episodic visits provided to children unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal State periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch-up EPSDT screening is defined as a complete screening that is provided to bring a child up-to-date with the State's screening periodicity schedule.) Use data reflecting **date of service** within the fiscal year for such screening services or other documentation of such services furnished under capitated arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

CPT-4 codes: Preventive Medicine Services

99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39 years)
99391 Established patient under one year
99392 Established patient (ages 1-4 years)
99393 Established patient (ages 5-11 years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99431 Newborn care (history and examination)
99432 Normal newborn care

or

CPT-4 codes: Evaluation and Management Codes

99202-99205 New Patient
99213-99215 Established Patient

NOTE: These CPT-4 codes must be used in conjunction with codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

Line 7 - Screening Ratio - **Make no entries on this line.** This is a fixed number which divides 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 receive the number of initial and periodic screening services required by the state's periodicity schedule, adjusted by the proportion of the year for which they are Medicaid eligible.

Note: Line 7 may not exceed 100 percent.

Line 8 - Total Eligibles ---Who Should Receive at Least One Initial or Periodic Screen - **Make no entries on this line.** This is a fixed number which represents the number of persons who should receive at least one initial or periodic screen is dependent on each state's periodicity schedule. This line is calculated using the following methodology:

1. If the number entered on line 4 of this form is greater than 1, the number 1 will be used. If the number in line 4 is less than or equal to 1, the number on line 4 will be used. (This procedure will eliminate situations where more than one visit is expected in any age group in a year.).
2. The number from the calculation in (1.) above will be multiplied by the number in line 1 of the form and the product entered on line 8.

Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen –

- **ENTER** the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year. **Refer to codes in line 6. Note: The number entered in Line 9 should not exceed the number in Line 8.**

Line 10 - Participant Ratio - **Make no entries on this line.** This is a fixed number which divides line 9 by line 8. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

Note: Line 10 may not exceed 100 percent.

Line 11 - Total Eligibles Referred for Corrective Treatment –

- **ENTER** the unduplicated number of individuals, including those in managed care arrangements, who, as the result of at least one health problem identified during an initial or periodic screening service, including vision and hearing screenings, were scheduled for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment services. This element does not include correction of health problems during the course of a screening examination.

Line 12a - Total Eligibles Receiving Any Dental Services –

- **ENTER** the unduplicated number of children receiving any dental service as defined by HCPC codes D0100 - D9999 (ADA codes D0100 - D9999). "Unduplicated" means that each child is counted only once for purposes of this line even if multiple services were received.

Line 12b - Total Eligibles Receiving Preventive Dental Services –

- **ENTER** the unduplicated number of children receiving a preventive dental service as defined by HCPC codes D1000 - D1999 (ADA codes D1000 - D1999). "Unduplicated" means that each child is counted only once even if more than one preventive service was provided.

Line 12c - Total Eligibles Receiving Dental Treatment Services –

- **ENTER** the unduplicated number of children receiving treatment services as defined by HCPC codes D2000 - D9999 (ADA codes D2000 - 09999). Unduplicated means that each child is counted only once even if more than one treatment service was provided.

Lines 12b and 12c do not equal to total services reflected on line 12a.

NOTE: For purposes of reporting the information on dental services, "unduplicated" means that each child is counted once for each line of data requested. For example, a child is counted once on line 12a for receiving any dental service and counted again for line 12b and/or 12c if the child received a preventive and/or treatment dental service. These numbers reflect services received in fee-for-service and managed care arrangements.

Line 13 - Total Eligibles Enrolled in Managed Care - This number is reported for informational purposes only.

- **ENTER** the number of individuals eligible for EPSDT services in your State who are enrolled in any type of managed care arrangement at any time during the reporting year. It includes any capitated arrangements such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager regardless of whether reimbursement is fee-for-service or capitated. Include these individuals in the total number of eligibles on line 1; 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.

Line 14 - Total Number of Screening Blood Lead Tests –

- **ENTER** the total number of screening blood lead tests furnished to eligible individuals under the fee-for-service or managed care arrangement. Do not count blood lead tests done on persons who have been diagnosed or treated for lead poisoning. **Do not make entries in the shaded columns.**

To report number of screening blood lead tests do the following: Count the number of times CPT code 83655 ("lead") or any State-specific (local) codes used for a blood lead tests reported with

any ICD-9-CM except with diagnosis codes 984 (.0-.9)("Toxic Effects of Lead and Its Compounds"), E861.5 ("Accidental Poisoning by Petroleum Products, Other Solvents and Their Vapors NEC: Lead Paints"), and E866.0 ("Accidental Poisoning by Other Unspecified Solid and Liquid Substances: Lead and Its Compounds and Fumes"). These specific ICD-9-CM diagnosis codes are used to identify people who are lead poisoned. Blood lead tests done in these individuals do not count as a screening blood lead test.

F. 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 28 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.