2700.4 Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report

Effective for reporting period federal fiscal year 2014 (October 1, 2013 through September 30, 2014), with submission of Form CMS-416 by April 1, 2015.

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 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. 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. Participation and screening goals are two different standards against which EPSDT performance (or penetration) 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 decisions 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. These data must include services reimbursed directly by the state under fee-for-service, or through managed care, prospective payment, or other payment arrangement or through any other health or dental plans that contract with the state. Each state is required to collect encounter data (or other data as necessary) from managed care and prospective payment entities in sufficient detail to provide the information required by this report. 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'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 2014, beginning October 1, 2013 through September 30, 2014, for data due to CMS on the form CMS-416 on or before April 1, 2015.

D. Submittal Procedure -- 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. The **electronic form and instructions** are available on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html. States may **not** modify the electronic form. It must be submitted as downloaded. A "hard copy" submittal to CMS is no longer required.

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.

E. Detailed Instructions -- **Enter your state name and the federal fiscal year as directed below.** For each of the following line items, report total counts by the age groups indicated and by whether categorically or medically needy (described below). In cases where calculations are necessary, perform separate calculations for the total column and for each age group. **You must enter a number in each line and column of data requested even if the number is "0."**

Important Reporting Requirements:

- Report age based upon the individual's age as of September 30 of the reporting year.
- Report all data in the age category reflecting the individual's age at the end of the federal fiscal year even if the individual 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.
- Screening data on Line 3a through Line 14 should reflect unduplicated counts of individuals from **Line 1b** (individuals enrolled for at least 90 continuous days during the reporting period).
- The objective of CMS-416 reporting is to capture on each line all services that were provided, regardless of payment status and unduplicated by child. Report data based on visits during which a service was provided to an eligible individual during the reporting period, according to the instructions for each line, regardless of whether the unduplicated claim was paid, unpaid, or denied. States must be able to ensure that once a service is reported on the CMS-416, it is not reported again in any reporting period if payment status changes, for example, from unpaid to paid.

State -- Enter the name of your state using the two character state code in upper case format.

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 2014 is October 1, 2013 through September 30, 2014.

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. "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, and that a claim for a service that was provided is only counted once, whether the claim was unpaid, paid, or denied. Include all individuals regardless of whether the services are provided under fee-for-service, prospective payment, managed care, or other payment arrangements. 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. Individuals for whom third-party liability is available should also be counted in the number.

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

- Medically needy individuals under the age of 21 if your state does **not** provide EPSDT services for the medically needy group;

- Individuals eligible for Medicaid only under a Section 1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available;
- Undocumented aliens who are eligible only for emergency Medicaid services;
- Children in separate state CHIP programs; or
- Other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).

Line 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 or a CHIP Medicaid expansion program for at least 90 continuous days in the federal fiscal year and determined to be eligible for EPSDT services, distributed by age and by basis of eligibility. For example, if an individual was enrolled from October 1 to November 30 and again from August 1 to September 30, the individual would not be considered eligible for 90 continuous days in the federal fiscal year.

Line 1c -- Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion Program -- Enter the total unduplicated 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. 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 a CHIP Medicaid expansion as of September 30.

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 medical periodicity schedule. (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.) **Make no entry in the total column.**

Note: As noted above, use the state's current medical periodicity schedule to complete Line 2a and submit a copy of the state's current medical and dental periodicity schedules to CMS with your CMS-416 submission.

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 -- 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 3a -- Total Months of Eligibility -- Enter the total months of eligibility for the individuals in each age group in Line 1b during the reporting year. An individual child should only be counted once in the age group the individual is in as of September 30. **Include the total months of eligibility in the age category where the individual is reported, even if the individual had months of eligibility in two age categories during the reporting period. For example, if an individual was eligible for 12 months, from October 1st through September 30th, but turned age 3 on August 1st, all 12 months of eligibility would be counted in the age 3-5 category.**

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 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 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 6 -- Total Screens Received -- Enter the total number of initial or periodic screens furnished to eligible individuals from Line 1b under fee-for-service, prospective payment, managed care or other payment arrangements, based on an unduplicated paid, unpaid, or denied claim.

Note: States may use the CPT codes listed below as a proxy for reporting these initial or periodic 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. (See Appendix I for a list of ICD-10 codes relevant to reporting on line 6, pending ICD-10 implementation.)

This number should <u>not</u> reflect sick visits or episodic visits provided to the enrolled individual 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 an individual child up-to-date with the state's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on the CMS-416.) **Report all screening data in the age category reflecting the individual's age at the end of the federal fiscal year even if the individual 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 the previous March, the 30-month visit would be counted in the age 3-5 age category.** Use the codes below or other documentation of such services furnished under capitated or prospective payment 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 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant

99463 Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)
***These CPT codes do not require use of a "V" code.**

OR

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 codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-V70.9.**

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 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 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 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 11 -- Total Eligibles Referred for Corrective Treatment -- Enter the unduplicated number of individuals from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who had a paid, unpaid, or denied claim for a visit/service that occurred within 90 days from the date of an initial or periodic screening within the reporting period, where none of the following is included as part of the claim: capitation payments, administrative fees, transportation services, nursing home services, ICF-MR services, HIPP payments, inpatient services, dental care, home health services, long-term care services, or pharmacy services. Include only those instances where both the

screening and the visit/service for which the subsequent claim was processed occurred within the reporting period.

Dental Lines 12a – 12g

NOTE A: For purposes of reporting the information on dental and oral health services in Lines 12a – 12g, "unduplicated" means that an individual may be counted only once on each line. However, an individual may be counted on two or more lines. For example, individuals under the age of 21 may be 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 qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. These numbers should be inclusive of services reimbursed directly by the state under fee-for-service, or under managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to Medicaid or CHIP Medicaid expansion enrollees, based on an unduplicated paid, unpaid, or denied claim.

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. "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. For each line, the universe of appropriate procedure codes to report is provided in the instructions below (HCPCS or equivalent CDT or CPT codes).

IMPORTANT: All codes must be reported appropriately with respect to whether they represent "dental" or "oral health" services, based on provider type.

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 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 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 listed in Table 1, that is, 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 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 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 equivalent CDT 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.

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.

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 <u>or</u> 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.

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 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 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-9 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**.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of V15.86 (exposure to lead) or V82.5 (special screening for other conditions such as a screening for heavy metal poisoning) may be used to identify a person receiving a screening blood lead test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984.0 through 984.9 (toxic effect of lead and its compounds), or e861.5 (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

(See Appendix II for a crosswalk of ICD-9 codes to ICD-10 codes, pending implementation of ICD-10.)

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.

[1] Health Effectiveness Data and Information Set

APPENDIX I: Form CMS-416 EPSDT Reporting Instructions
ICD-10 Codes for Line 6
Total Screens Received
Pending Implementation of ICD-10

Line 6 -- Total Screens Received -- Enter the total number of initial or periodic screens furnished to eligible individuals from Line 1b under fee-for-service, prospective payment, or managed care arrangements.

Note: States may use the CPT codes listed below as a proxy for reporting these initial or periodic 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 the enrolled individual 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 an individual child up-to-date with the state's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on the CMS-416.) **Report all screening data in the age category reflecting the individual's age at the end of the federal fiscal year even if the individual 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.** Use the codes below 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 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant
99463 Initial hospital or birthing center care of normal newborn infant (admitted/ discharged same date)

***These CPT codes do not require use of a "Z" code.**

APPENDIX I: Form CMS-416 EPSDT Reporting Instructions
ICD-10 Codes for Line 6
Total Screens Received
<u>Pending</u> Implementation of ICD-10

<u>OR</u>

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:**

Z76.2 (Encounter for health supervision and care of other healthy infant and child),
Z00.121 (Encounter for routine child health examination with abnormal findings),
Z00.129 (Encounter for routine child health examination without abnormal findings),
Z00.110 (Health examination for newborn under 8 days old) and
Z00.111 (Health examination for newborn 8 to 28 days old)
and/or
Z00.00-01 (Encounter for general adult medical examination without/with abnormal findings),
and/or
Z02.0 (Encounter for examination for admission to educational institution),
Z02.1 (Encounter or pre-employment examination),
Z02.2 (Encounter for examination for admission to residential institution),
Z02.3 (Encounter for examination for recruitment to armed forces),
Z02.4 (Encounter for examination for driving license),
Z02.5 (Encounter for examination for participation in sport),
Z02.6 (Encounter for insurance purposes),
Z02.81 (Encounter for paternity testing),
Z02.82 (Encounter for adoption services),
Z02.83 (Encounter for blood-alcohol and blood-drug test),
Z02.89 (Encounter for other administrative examinations),
Z00.8 (Encounter for other general examination),
Z00.6 (Encounter for examination for normal comparison and control in clinical research program),
Z00.5 (Encounter for examination of potential donor of organ and tissue),
Z00.70 (Encounter for examination for period of delayed growth in childhood without abnormal findings),
Z00.71 Encounter for examination for period of delayed growth in childhood with abnormal findings).

Line 14 -- Total Number of Screening Blood Lead Tests -- Enter the total number of screening blood lead tests furnished to eligible individuals **from Line 1b** under fee-for-service, prospective payment, or managed care arrangements. 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®[2] measure developed by the National Committee for Quality Assurance to report blood lead screenings if your state had elected to use this performance measure**.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of Z77.011 (exposure to lead) or Z13.88 **(**Encounter for screening for disorder due to exposure to contaminants) may be used to identify a person receiving a screening blood lead test, or Z57.8 (occupational exposure to other risk factors). However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984.0 through 984.9 (toxic effect of lead and its compounds), T56.0X1A–4A (Toxic effect of lead and its compounds, initial encounter); M1A.10X0-1, M1A.1110-11, M1A.1120-21, M1A1190-91, M1A.1210-11, M1A.1610-11, M1A.1621, M1A.1690-91, M1A.1710-11, M1A1720-21, M1A.1790-91, M1A.18X0-X1, M1A.19X1A-X4A (**See below for a description of these codes**) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

[2] Health Effectiveness Data and Information Set

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.0 Toxic effect of inorganic lead compounds	**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter
984.1 Toxic effect of organic lead compounds	**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter
984.8 Toxic effect of other lead compounds	**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter
984.9 Toxic effect of unspecified lead compound	**M1A.10X0** Lead-induced chronic gout, unspecified site, without tophus (tophi), **M1A.10X1** Lead-induced chronic gout, unspecified site, with tophus (tophi) **M1A.1110** Lead-induced chronic gout, right shoulder, without tophus (tophi) **M1A.1111** Lead-induced chronic gout, right shoulder, with tophus (tophi) **M1A.1120** Lead-induced chronic gout, left shoulder, without tophus (tophi) **M1A.1121** Lead-induced chronic gout, left shoulder, with tophus (tophi) **M1A.1190** Lead-induced chronic gout, unspecified shoulder, without tophus (tophi) **M1A.1191** Lead-induced chronic gout, unspecified shoulder, with tophus (tophi) **M1A.1210** Lead-induced chronic gout, right elbow, without tophus (tophi)

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.9 Toxic effect of unspecified lead compound (continued from prior page)	**M1A.1211** Lead-induced chronic gout, right elbow, with tophus (tophi) **M1A.1220** Lead-induced chronic gout, left elbow, without tophus (tophi) **M1A.1221** Lead-induced chronic gout, left elbow, with tophus (tophi) **M1A.1290** Lead-induced chronic gout, unspecified elbow, without tophus (tophi) **M1A.1291** Lead-induced chronic gout, unspecified elbow, with tophus (tophi) **M1A.1310** Lead-induced chronic gout, right wrist, without tophus (tophi) **M1A.1311** Lead-induced chronic gout, right wrist, with tophus (tophi) **M1A.1320** Lead-induced chronic gout, left wrist, without tophus (tophi) **M1A.1321** Lead-induced chronic gout, left wrist, with tophus (tophi) **M1A.1390** Lead-induced chronic gout, unspecified wrist, without tophus (tophi) **M1A.1391** Lead-induced chronic gout, unspecified wrist, with tophus (tophi) **M1A.1410** Lead-induced chronic gout, right hand, without tophus (tophi) **M1A.1411** Lead-induced chronic gout, right hand, with tophus (tophi) **M1A.1420** Lead-induced chronic gout, left hand, without tophus (tophi) **M1A.1421** Lead-induced chronic gout, left hand, with tophus (tophi) **M1A.1490** Lead-induced chronic gout, unspecified hand, without tophus (tophi) **M1A.1491** Lead-induced chronic gout, unspecified hand, with tophus (tophi) **M1A.1510** Lead-induced chronic gout, right hip, without tophus (tophi) **M1A.1511** Lead-induced chronic gout, right hip, with tophus (tophi) **M1A.1520** Lead-induced chronic gout, left hip, without tophus (tophi) **M1A.1521** Lead-induced chronic gout, left hip, with tophus **M1A.1590** Lead-induced chronic gout, unspecified hip, without tophus (tophi)

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.9 Toxic effect of unspecified lead compound (continued from prior page)	**M1A.1591** Lead-induced chronic gout, unspecified hip, with tophus (tophi) **M1A.1610** Lead-induced chronic gout, right knee, without tophus (tophi) **M1A.1611** Lead-induced chronic gout, right knee, with tophus (tophi) **M1A.1620** Lead-induced chronic gout, left knee, without tophus (tophi) **M1A.1621** Lead-induced chronic gout, left knee, with tophus (tophi) **M1A.1690** Lead-induced chronic gout, unspecified knee, without tophus (tophi) **M1A.1691** Lead-induced chronic gout, unspecified knee, with tophus (tophi) **M1A.1710** Lead-induced chronic gout, right ankle and foot, without tophus (tophi) **M1A.1711** Lead-induced chronic gout, right ankle and foot, with tophus (tophi) **M1A.1720** Lead-induced chronic gout, left ankle and foot, without tophus (tophi) **M1A.1721** Lead-induced chronic gout, left ankle and foot, with tophus (tophi) **M1A.1790** Lead-induced chronic gout, unspecified ankle and foot, without tophus (tophi) **M1A.1791** Lead-induced chronic gout, unspecified ankle and foot, with tophus (tophi) **M1A.18X0** Lead-induced chronic gout, vertebrae, without tophus (tophi) **M1A.18X1** Lead-induced chronic gout, vertebrae, with tophus (tophi) **M1A.19X0** Lead-induced chronic gout, multiple sites, without tophus (tophi) **M1A.19X1** Lead-induced chronic gout, multiple sites, with tophus (tophi) **T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter

APPENDIX II: Form CMS-416 EPSDT Reporting Instructions
Crosswalk of ICD-9 Codes to ICD-10 Codes for Line 14
Total Number of Screening Blood Tests
Pending Implementation of ICD-10

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
V15.85 Personal history of contact with and (suspected) exposure to potentially hazardous body fluids	**Z57.8** Occupational exposure to other risk factors
V15.86 Personal history of contact with and (suspected) exposure to lead	**Z77.011** Contact with and (suspected) exposure to lead
V82.5 Screening for Chemical Poisoning and other contamination	**Z13.88** Encounter for screening for disorder due to exposure to contaminants