CMS-416 Final Revised Instructions

Questions and Answers

February 2015

Unpaid and Denied Claims

Question 1: What is the definition of an unpaid claim on the CMS-416?

Answer: For purposes of reporting on the CMS-416, an unpaid claim is any claim that is not yet paid, i.e., zero payment, denied, or pended, but that meets the criteria of a Medicaid-eligible individual provided a service.

Question 2: Can "0" pay claims be counted on the CMS-416?

Answer: Zero pay claims for Medicaid payment due to full reimbursement by another payer, or bundling of services, can be counted on the CMS-416.

Question 3: Can rejected claims be counted on the CMS-416?

Answer: Yes, rejected claims can be included on the CMS-416 if the service was provided to a Medicaid-eligible individual.

Question 4: What is the definition of a denied claim? When can we count a denied claim vs. not count it?

Answer: For the purposes of reporting on the CMS-416, a denied claim is one in which the payment of claim was denied by the state for state-defined administrative reasons. Count only claims denied for state-defined administrative reasons. These represent those claims that are for services provided to eligible members that are denied for administrative issues such as failure to obtain prior authorization, inadequate documentation, or timeliness. Do not count denied claims for which there is doubt about whether a service actually was provided.

Question 5: Should claims that are denied because of a missing or invalid Medicaid recipient ID be included even though we would be unable to correctly classify them as categorically needy (CN) or medically needy (MN), or de-duplicate the beneficiary?

Answer: No. Denied claims in which the state would be unable to correctly classify a child's eligibility status, or de-duplicate the child within a reporting line, should not be included on the CMS-416.

Question 6: Does CMS want states to bring in managed care organizations' (MCOs') denied encounters and report on them on the CMS-416?

Answer: See answer to #4 above. If the MCO's denied encounters meet the criteria of a service provided to eligible members, and are denied for state defined administrative reasons, such as failure to obtain prior authorization, inadequate documentation, or timeliness, then these claims

can be included on the report. If your state's process does not input these denied encounters into the MMIS system, then changes may be necessary so that they can be included in MMIS for CMS-416 reporting purposes.

Eligibility

Question 7: How do we report the medically needy (MN) and categorically needy (CN) eligibility categories on the CMS-416? What timeframe is this based on?

Answer: Children should be reported as medically needy (with or without spend down) or categorically needy (not medically needy) based on their status as of September 30, the end of the reporting federal fiscal year. If a child was not enrolled in Medicaid on September 30 because their eligibility was terminated prior to that date, their status should be as of when they were terminated, within the other parameters for including children on the report, as identified in the instructions.

Crosswalk from Current Procedural Terminology (CPT) to Current Dental Terminology (CDT) Codes

Question 8: Why doesn't the current version (11/17/14, Version 3) of the revised CMS-416 instructions include Table 1, a crosswalk from CPT codes to CDT codes, that was included in previous versions? Will CMS make it available again?

Answer: There are two reasons why CMS removed Table 1 from Version 3 of the 416 instructions. First, CMS was concerned that the crosswalk might be under-inclusive, leaving out some CPT codes relevant to dental services. Second, CMS could not verify that all CPT codes included in Table 1 were dental-related, and thus was concerned that Table 1 might be over-inclusive. After further research, CMS has posted a CPT-to-CDT crosswalk on Medicaid.gov, though it is likely still both over-and-under-inclusive.

Given these limitations, this CPT-CDT crosswalk should be viewed as a tool to assist states in reporting CPT codes on the dental lines of the CMS-416, and not as the universe of CPT codes related to dental care, nor as a set of CPT codes which describe only dental-related procedures. We ask that anyone using the crosswalk to inform reporting on the CMS-416 take responsibility for ensuring that all CPT codes reported on the CMS-416 are for dental services only.

CMS will continue to refine this crosswalk, with plans to release an updated version prior to April 1, 2016 to inform FFY 2015 CMS-416 reporting.

Crosswalk from ICD-9 to ICD-10 Codes

Question 9: Will CMS be providing states with a crosswalk of all ICD-9 codes to ICD-10 codes?

Answer: CMS provided a crosswalk from ICD-9 codes to ICD-10 codes for Lines 6 and 14 on the CMS-416 (Total Screens Received and Total Number of Screening Blood Tests, respectively.) as part of the revised instructions. CMS will not be providing any further crosswalk from ICD-9 codes to ICD-10 codes.

Separate CHIP Reporting

Question 10: We understand that data on individuals in a CHIP Medicaid expansion are included on the CMS-416. If a state makes the EPSDT benefit available for its separate CHIP population, can data on these individuals also be included on the CMS-416?

Answer: No, the CMS-416 is intended only for reporting on children enrolled in Medicaid or CHIP Medicaid expansion programs. States are asked to report on children enrolled in separate CHIP programs as part of the CHIP Annual Report Template System, or CARTS. For more information about CARTS, please contact CARTSHELP@cms.hhs.gov.

Oral Health

Question 11: If a state reimburses primary care physicians separately for an oral health evaluation performed during a well-child visit, and the dentist also claims for an oral health evaluation, can both claims be counted on the CMS-416?

Answer: Yes, both claims can, and should be, counted on the CMS-416. The oral health evaluation by a primary care physician should be counted on Line 12f (oral health services by a non-dentist) and the dentist's claim for an oral evaluation should be reported on Line 12e (diagnostic services by or under the supervision of a dentist). In states where the primary care physician is not paid separately for performing an oral health evaluation, that is, when such an activity is bundled in to the payment for the well-child check-up, that oral health evaluation should not be reported on Line 12f or any other line. In states where primary care physicians are paid separately for applying fluoride varnish during well-child check-ups (or at other visits), those fluoride varnish applications should be counted on Line 12f (oral health services by a non-dentist).

Line 11 - Referral for Corrective Treatment

Question 12: Other than the excluded types of services that are listed, are there any other limitations on how a corrective treatment is defined besides "a paid claim for a visit/service that occurred within 90 days from the date of an initial or periodic screening within the reporting period"? For example, a Medicaid enrollee might receive a screening, and within 90 days of that screening, also go to the doctor for the flu. How do we distinguish between a treatment and some other type of doctor visit using the 90-day rule? Should all doctor visits occurring within 90 days of a screening be considered treatments?

Answer: Yes, all doctor visits occurring within 90 days of an initial or periodic screening should be captured on this line, with the exception of the exclusions noted in the instructions.

CMS's intention for the revised instructions for Line 11 was to develop a consistent approach to state reporting that closely approximates a referral for corrective treatment, in the absence of a more precise measurement. We do understand that this approach will have some limitations. However, we view this approach as an improvement over what states have reported in the past by providing information at least roughly comparable across states.

Line 14 - Total Number of Screening Blood Tests

Question 13: Line 14 does not indicate that screening blood tests must be unduplicated. If a child has two screening blood tests in the measurement year, do we count both tests on Line 14, or just one?

Answer: Screening blood tests can be duplicated within a reporting period on Line 14. Meaning, if one child has two tests in the measurement year, both tests should be counted on Line 14.