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

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 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 the associated instructions must be used effective fiscal year 2015, beginning October 1, 2014 through September 30, 2015, for data due on or after April 1, 2016.

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 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 Bright Futures™, 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 data report.

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 and medically needy. In cases where calculations are necessary, perform separate

calculations for the total column and each age group. **You must enter a number in each line and column of data requested even if the number is "0."**

Helpful Notes about Reporting:

- 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).
- Report data on visits based only on adjudicated, i.e., paid claims.

**State** -- Enter the name of your state using 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 2015 is October 1, 2014 through September 30, 2015.

**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. Include all individuals regardless of whether the services are provided under fee-for-service, prospective payment, or managed care arrangements. States should determine the basis of eligibility consistent with the instructions from the Medicaid Statistical Information System (MSIS) Data Dictionary. 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: 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; 4) children in separate state CHIP programs; or 5) 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 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 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 August 1st to September 30th and October 1st to November 30, the individual would <u>not</u> 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 CHIP 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 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.) **Make no entry in the total column.**

**Note: 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** -- 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 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 remain 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, 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.**

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 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 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 receive 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 are Medicaid 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 enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year. **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 managed care arrangements, who had a paid claim for a visit/service that occurred within 90 days from the date of an initial or periodic screening where none of the following is included as part of the paid 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 paid 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 for each line of dental or oral health data. 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 non-dentist or by a dental professional not working 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 through any other private health or dental plans that contract with the state.

**NOTE B**: We use the term "dental services" to refer 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 dental practice act. We use the term "oral health services" to refer to services provided by a health care practitioner working within their scope of practice and 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 (HCPCS and CDT) or on Table 1 (CPT).

**Line 12a -- Total Eligibles Receiving Any Dental Services** -- Enter the unduplicated number of individuals under the age of 21 with at least 90 days continuous 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 (CDT codes D0100 - D9999) or the CPT codes listed in Table 1. 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 days continuous 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 (CDT codes D1000 - D1999) or the CPT codes listed in Table 1. 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 days continuous 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 (CDT codes D2000 – D9999) or the CPT codes listed in Table 1. See Notes A and B, above.

**Line 12d -- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth** -- Enter the unduplicated number of individuals under the age of 21 with at least 90 days continuous 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 (CDT code D1351). For this line, include sealants placed by any dental professional for who 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 days continuous 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 D0120 – D0191 (CDT codes D0120 – D0191) or the CPT codes listed in Table 1. 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 days continuous enrollment during the federal fiscal year from Line 1b who received at least one oral health service, as defined by HCPCS, CDT, CPT (see Table 1), ICD-9 or ICD-10 codes, including CDT D0190 (screening) and CDT D0191 (assessment). A "non-dentist provider" is any health care practitioner working within their scope practice and 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 days continuous enrollment during the federal fiscal year from Line 1b who received either a "dental service" by or under the supervision of a dentist or an "oral health service" by a health care practitioner working within their scope of practice and who is neither a dentist nor providing services under the supervision of a dentist. 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. 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 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.

**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®[1] 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

[1] Health Effectiveness Data and Information Set

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 Table 2 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.

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.

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| | | Diagnostic - Report these codes on lines 12a, 12e and 12g if performed by or under the supervision of a dentist; report them on lines 12f and 12g if performed by a health care practitioner working within their scope of practice and who is neither a dentist nor providing services under the supervision of a dentist. |
| D0210 | Intraoral - complete series (including bitewings) | 70300, 70310, 70320 |
| D0220 | Intraoral - periapical first film | 70300, 70310, 70320 |
| D0230 | Intraoral - periapical each additional film | 70300, 70310, 70320 |
| D0240 | Intraoral - occlusal film | 70300, 70310, 70320 |
| D0250 | Extraoral - first film | 70300, 70310, 70320 |
| D0260 | Extraoral - each additional film | 70300, 70310, 70320 |
| D0270 | Bitewing - single film | 70300, 70310, 70320 |
| D0272 | Bitewings - two films | 70300, 70310, 70320 |
| D0273 | Bitewings - three films | 70300, 70310, 70320 |
| D0274 | Bitewings - four films | 70300, 70310, 70320 |
| D0277 | Vertical bitewings - 7 to 8 films | 70300, 70310, 70320 |
| D0290 | Posterior-anterior or lateral skull and facial bone survey film | 70140, 70150, 70250, 70260 |
| D0310 | Sialography | 70390 |
| D0320 | Tempromandibular joint arthrogram, including injection | 21116, 70332 |
| D0321 | Other temporomandibular joint arthrogram, including injection | 70328, 70330, 76499 |
| D0322 | Tomographic survey | 70486 |

| | | |
|---|---|---|
| D0330 | Panoramic film | 70320, 70355 |
| D0340 | Cephalometric film | 70350 |
| **(Form CMS-416)** | **Nomenclature** | **CPT Codes** |
| D0360 | Cone beam CT - craniofacial data capture | 70486, 70487, 70488 |
| D0362 | Cone beam - two-dimensional image reconstruction using existing data includes multiple images | 70486 |
| D0363 | Cone beam - three-dimensional image reconstruction using existing data, includes multiple images | 76376 |
| D0364 | Cone beam CT capture and interpretation with limited field of view - less than one whole jaw | 70486, 70487, 70488 |
| D0365 | Cone beam CT capture and interpretation with field of view of one full dental arch - mandible | 70486, 70487, 70488 |
| D0366 | Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium | 70486, 70487, 70488 |
| D0367 | Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium | 70486, 70487, 70488 |
| D0368 | Cone beam CT capture and interpretation for TMJ series including two or more exposures | 70486, 70487, 70488 |
| D0369 | Maxillofacial MRI capture and interpretation | 70540, 70542, 70543 |

| | | |
|---|---|---|
| D0380 | Cone beam CT capture with limited field of view - less than one whole jaw | 70486-TC, 70487-TC, 70488- TC |

| **(Form CMS-416)** | **Nomenclature** | **CPT Codes** |
|---|---|---|
| D0381 | Cone beam CT capture with field of view of one full dental arch - mandible | 70486-TC, 70487-TC, 70488- TC |
| D0382 | Cone beam CT capture with field of view of one full dental arch - maxilla, with or | 70486-TC, 70487-TC, 70488- TC |
| D0383 | Cone beam CT capture with field of view of both jaws; with or without | 70486-TC, 70487-TC, 70488- TC |
| D0384 | Cone beam CT capture for TMJ series including two or more exposures | 70486-TC, 70487-TC, 70488- TC |
| D0385 | Maxillofacial MRI capture | 70540-TC, 70542-TC, 70543- TC |
| D0391 | Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report | Any radiology code consistent with the image being reviewed with a modifier -26 appended to the CPT code |
| D0415 | Collection of microorganisms for culture and sensitivity | 87070, 87071, 87207, 87999, 99000, 99001 |
| D0416 | Viral culture | 87070, 87071, 87207, 87999, 99000, 99001 |
| D0417 | Collection and preparation of saliva sample for laboratory diagnostic testing | 87070, 87071, 87081, 87207, 87999, 99000, 99001 |
| D0418 | Analysis of saliva sample | 87070, 87071, 87081, 87207, 87999 |
| D0421 | Genetic test for susceptibility to oral diseases | 87181, 87184, 99000, 99001 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D0425 | Caries susceptibility tests | 87181, 87184, 99000, 99001 |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | 82397 |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | 88300 |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | 88302, 88304, 88305, 88307 |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | 88305, 88307 |
| D0475 | Decalcification procedure | 88311 |
| D0476 | Special stains for microorganisms | 88312, 88313, 99000, 99001 |
| D0477 | Special stains, not for microorganisms | 87207, 87209, 99000, 99001 |
| D0478 | Immunohistochemical stains | 88314, 99000, 99001 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D0479 | Tissue in-situ hybridization, including interpretation | 88365, 88367, 99000, 99001 |
| D0480 | Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report | 88104, 88112, 99000, 99001 |
| D0481 | Electron microscopy - diagnostic | 88104, 88112, 99000, 99001 |
| D0482 | Direct immunofluorescence | 88346, 99000, 99001 |
| D0483 | Indirect immunofluorescence | 88347, 99000, 99001 |
| D0484 | Consultation on slides prepared elsewhere | 80500, 80502, 88321, 88323 |
| D0485 | Consultation, including preparation of slides from biopsy material supplied by referring source | 80500, 80502, 88321, 88323 |
| D0486 | Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report | 88160, 88161, 88162 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| | | Preventive - Report these codes on lines 12a, 12b and 12g if performed by or under the supervision of a dentist; report them on lines 12f and 12g if performed by a health care practitioner working within their scope of practice and who is neither a dentist nor providing services under the supervision of a dentist. |
| D1310 | Nutritional counseling for control of dental disease | 96152 |
| D1320 | Tobacco counseling for the control and prevention of oral disease | 96152, 4000F |
| D1330 | Oral hygiene instructions | 96152 |
| | | Periodontics, Maxillofacial Prosthetics, Implants, Oral & Maxillofacial Surgery, Adjunctive General Services - Report these codes on lines 12a, 12c and 12g if performed by or under the supervision of a dentist; report them on lines 12f and 12g if performed by a health care practitioner working within their scope of practice and who is neither a dentist nor providing services under the supervision of a dentist. |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | 41820, 41872 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | 41820, 41872 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | 41820, 41872 |
| D4230 | Anatomical crown exposure - four or more contiguous teeth per quadrant | 41820, 41821 |
| D4231 | Anatomical crown exposure - one to three teeth per quadrant | 41820, 41821 |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | 41870 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | 41870 |
| D4245 | Apically positioned flap | 41870 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded by spaces per quadrant | 41823 |
| D4261 | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded by spaces per quadrant | 41823 |
| D4263 | Bone replacement graft - first site in quadrant | 21127 |
| D4264 | Bone replacement graft - each additional site in quadrant | 21127 |
| D4266 | Guided tissue regeneration - resorbable barrier, per site | 41870 |
| D4267 | Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) | 41870 |
| D4270 | Pedicle soft tissue graft procedure | 15574 |
| D4271 | Free soft tissue graft procedure (including donor site surgery) | 41870 |
| D4275 | Soft tissue allograft | 41870 |
| D4276 | Combined connective tissue and double pedicle graft, per tooth | 41870 |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report | 41899 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D4999 | Unspecified periodontal | 41899 |
| D5913 | Nasal prosthesis | 21087 |
| D5914 | Auricular prosthesis | 21086 |
| D5915 | Orbital prosthesis | 21077 |
| D5919 | Facial prosthesis | 21088 |
| D5932 | Obturator prosthesis, definitive | 21080 |
| D5934 | Mandibular resection prosthesis with guide flange | 21081 |
| D5935 | mandibular resection prosthesis without guide flange | 21081 |
| D5936 | Obturator prosthesis, interim | 21079 |
| D5952 | Speech aid prosthesis, pediatric | 21084 |
| D5953 | Speech aid prosthesis, adult | 21084 |
| D5954 | Palatal augmentation | 21082 |
| D5955 | Palatal lift prosthesis, definitive | 21083 |
| D5958 | Palatal lift prosthesis, interim | 21083 |
| D6010 | Surgical replacement of implant body: endosteal implant | 21248 |
| D6012 | Surgical placement of interim implant body for transitional prosthesis: endosteal implant | 21248 |
| D6040 | Surgical placement: eposteal implant | 21248 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D6050 | Surgical placement: transosteal implant | 21248 |
| D7260 | Oroantral fistula closure | 30580, 30600 |
| D7261 | Primary closure of a sinus perforation | 30580, 30600 |
| D7285 | Biopsy of oral tissue - hard (bone, tooth) | 20220, 20240 |
| D7286 | Biopsy of oral tissue - soft | 11100, 11101, 40808 |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 41870, 41874 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 41870, 41874 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 41874 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 41874 |
| D7340 | Vestibuloplasty - ridge extension (secondary | 40840, 40842, 40843, 40844 |
| D7350 | Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | 40845 |
| D7410 | Excision of benign lesion up to | 40810, 40812, 40814 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7411 | Excision of benign lesion greater than | 40810, 40812, 40814 |
| D7412 | Excision of benign lesion, complicated | 40814, 40816 |
| D7413 | Excision of malignant lesion up to 1.25 cm | 40810, 40812, 40814 |
| D7414 | Excision of malignant lesion greater than 1.25 cm | 40810, 40812, 40814 |
| D7415 | Excision of malignant lesion, complicated | 40814, 40816 |
| D7440 | Excision of malignant tumor - lesion diameter up to 1.25 cm | 21034, 21044 |
| D7441 | Excision of malignant tumor - lesion diameter greater than | 21034, 21044 |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | 41825, 41826, 41827 |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | 41825, 41826, 41827 |
| D7460 | Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm | 41825, 41826, 41827 |
| D7461 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | 41825, 41826, 41827 |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report | 40820, 41850 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7471 | Removal of lateral exostosis (maxilla or mandible) | 21031, 21032 |
| D7472 | Removal of torus palatinus | 21032 |
| D7473 | Removal of torus mandibularis | 21031 |
| D7485 | Surgical reduction of osseous tuberosity | 41823 |
| D7490 | Radical resection of maxilla or mandible | 21045 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | 40800, 41800 |
| D7511 | Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces | 40801, 41800 |
| D7520 | Incision and drainage of abscess - extraoral soft tissue | 40801, 41800 |
| D7521 | Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces | 40801, 41800 |
| D7530 | Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue | 40804, 40805, 41805 |
| D7540 | Removal of reaction producing foreign bodies, musculoskeletal system | 20520, 20525, 40804, 40805, 41806 |
| D7610 | Maxilla - open reduction (teeth immobilized, if present) | 21422, 21423 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7620 | Maxilla - closed reduction (teeth immobilized, if present) | 21421 |
| D7630 | Mandible - open reduction (teeth immobilized, if present) | 21454, 21461, 21462, 21470 |
| D7640 | Mandible - closed reduction (teeth immobilized, if present) | 21450, 21451, 21453 |
| D7650 | Malar and/or zygomatic arch - open reduction | 21356, 21360, 21365, 21366 |
| D7660 | Malar and/or zygomatic arch - closed reduction | 21355 |
| D7670 | Alveolus - closed reduction, may include stabilization of teeth | 21440 |
| D7671 | Alveolus - open reduction, may include stabilization of teeth | 21445 |
| D7680 | Facial bones - complicated reduction with fixation and multiple surgical approaches | 21433, 21435 |
| D7710 | Maxilla - open reduction | 21422, 21423 |
| D7720 | Maxilla - closed reduction | 21421 |
| D7730 | Mandible - open reduction | 21454, 21461, 21462, 21470 |
| D7740 | Mandible - closed reduction | 21450, 21451, 21453 |
| D7750 | Malar and/or zygomatic arch - open reduction | 21356, 21360, 21365, 21366 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7760 | Malar and/or zygomatic arch - closed reduction | 21355 |
| D7770 | Alveolus - open reduction stabilization of teeth | 21445 |
| D7771 | Alveolus - closed reduction stabilization of teeth | 21440 |
| D7780 | Facial bones - complicated reduction with fixation and multiple surgical approaches | 21433, 21435 |
| D7810 | Open reduction of dislocation | 21490 |
| D7820 | Closed reduction of dislocation | 21480, 21485 |
| D7830 | Manipulation under anesthesia | 21073 |
| D7840 | Condylectomy | 21050 |
| D7850 | Surgical discectomy, with/without implant | 21060 |
| D7858 | Joint reconstruction | 21242, 21243 |
| D7860 | Arthrotomy | 21010 |
| D7865 | Arthroplasty | 21240 |
| D7870 | Arthrocentesis | 20605 |
| D7872 | Arthroscopy - diagnosis, with or without biopsy | 29800 |
| D7873 | Arthroscopy - surgical: lavage and lysis of adhesions | 29804 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7874 | Arthroscopy - surgical: disc repositioning and stabilization | 29804 |
| D7875 | Arthroscopy - surgical: synovectomy | 29804 |
| D7876 | Arthroscopy - surgical: discectomy | 29804 |
| D7877 | Arthroscopy - surgical: debridement | 29804 |
| D7910 | Suture of recent small wounds up to 5 cm | 12011, 12013, 40830, 40831, 41250, 41251, 41252, 42180, 42182 |
| D7911 | Complicated suture - up to 5 cm | 12051, 12052, 13131, 13132, 13150, 13151, 13152, 40831, 41252, 42182 |
| D7912 | Complicated suture - greater than 5 cm | 12053, 12054, 12054, 12055, 12056, 12057, 13132, 13133, 13152, 13153, 40831, 41252, 42182 |
| D7940 | Osteoplasty - for orthognathic deformities | 21208, 21209 |
| D7941 | Osteotomy - mandibular rami | 21193, 21195, 21196 |
| D7943 | Osteotomy - mandibular rami with bone graft; includes obtaining the graft | 21194 |
| D7944 | Osteotomy - segmented or subapical | 21198, 21199, 21206 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7945 | Osteotomy - body of mandible | 21193, 21194, 21195, 21196 |
| D7946 | LeFort I (maxilla - total) | 21141, 21142, 21143, 21145, 21147 |
| D7947 | LeFort I (maxilla - segmented) | Any of the codes crosswalked to D7946 would be appropriate, but should be reported with a -52 modifier |
| D7948 | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft | 21150 |
| D7949 | LeFort II or LeFort III - with bone graft | 21151, 21154, 21155, 21159, 21160 |
| D7950 | Osseous, osteoperiosteal, or cartilage graft of the madible or maxilla - autogenous or nonautogenous, by report | 21210, 21215 |
| D7960 | Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another | 40806, 40819, 41010, 41115 |
| D7963 | Frenuloplasty | 41520 |
| D7970 | Excision of hyperplastic tissue per arch | -41828 |
| D7971 | Excision of pericoronal gingiva | 41821 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D7972 | Surgical reduction of osseous tuberosity | 41822 |
| D7980 | Sialolithotomy | 42330, 42335, 42340 |
| D7981 | Excision of salivary gland, by report | 42410, 42415, 42420, 42425, 42426, 42440, 42450 |
| D7982 | Sialodochoplasty | 42600 |
| D7983 | Closure of salivary fistula | 42600 - Closure salivary fistula |
| D7990 | Emergency tracheotomy | 31603, 31605 |
| D7991 | Coronoidectomy | 21070 |
| D7996 | Implant - mandible for augmentation purposes (excluding alveolar ridge), by report | 21125, 21127 |
| D9212 | Trigeminal division block anesthesia | 64400 |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | 00170, 00172, 00174, 00176 |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | 00170, 00172, 00174, 00176 |
| D9241 | Intravenous conscious sedation/analgesia - first 30 minutes | 99143, 99144, 99148, 99149 |
| D9242 | Intravenous conscious sedation/analgesia - each additional 15 minutes | 99145, 99150 |

Table 1 to CMS 416 Reporting Instructions for Lines 12a through 12g
Crosswalk of CPT Codes to CDT Codes

| (Form CMS-416) | Nomenclature | CPT Codes |
|---|---|---|
| D9310 | Consultation - diagnostic service provided by a dentist or physician other than requesting dentist or physician | Office consultation - 99241, 99242, 99243, 99244, 99245<br>Inpatient consultation - 99251,<br>99252, 99253, 99254, 99255 |

## Table 2: Form CMS-416 EPSDT Reporting Instructions
## Crosswalk of ICD-9 to ICD-10 Codes for Line 14
## Total Number of Screening Blood Lead Tests

| ICD-9 Codes (Form CMS-416) | ICD-10 Codes and Description (for Form CMS-416) effective 10/1/2014 |
|---|---|
| **984.0** Toxic effect of inorganic lead compounds | **T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter<br>**T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter<br>**T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter<br>**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<br>**T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter<br>**T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter<br>**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<br>**T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter<br>**T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter<br>**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),<br>**M1A.10X1** Lead-induced chronic gout, unspecified site, with tophus (tophi)<br>**M1A.1110** Lead-induced chronic gout, right shoulder, without tophus (tophi)<br>**M1A.1111** Lead-induced chronic gout, right shoulder, with tophus (tophi)<br>**M1A.1120** Lead-induced chronic gout, left shoulder, without tophus (tophi)<br>**M1A.1121** Lead-induced chronic gout, left shoulder, with tophus (tophi)<br>**M1A.1190** Lead-induced chronic gout, unspecified shoulder, without tophus (tophi) |

## Table 2: Form CMS-416 EPSDT Reporting Instructions
## Crosswalk of ICD-9 to ICD-10 Codes for Line 14
## Total Number of Screening Blood Lead Tests

| ICD-9 Codes (Form CMS-416) | ICD-10 Codes and Description (for Form CMS-416) effective 10/1/2014 |
|---|---|
| **984.9** Toxic effect of unspecified lead compound<br><br>(continued from prior page) | **M1A.1191** Lead-induced chronic gout, unspecified shoulder, with tophus (tophi)<br>**M1A.1210** Lead-induced chronic gout, right elbow, without tophus (tophi)<br>**M1A.1211** Lead-induced chronic gout, right elbow, with tophus (tophi)<br>**M1A.1220** Lead-induced chronic gout, left elbow, without tophus (tophi)<br>**M1A.1221** Lead-induced chronic gout, left elbow, with tophus (tophi)<br>**M1A.1290** Lead-induced chronic gout, unspecified elbow, without tophus (tophi)<br>**M1A.1291** Lead-induced chronic gout, unspecified elbow, with tophus (tophi)<br>**M1A.1310** Lead-induced chronic gout, right wrist, without tophus (tophi)<br>**M1A.1320** Lead-induced chronic gout, left wrist, without tophus (tophi)<br>**M1A.1321** Lead-induced chronic gout, left wrist, with tophus (tophi)<br>**M1A.1390** Lead-induced chronic gout, unspecified wrist, without tophus (tophi)<br>**M1A.1391** Lead-induced chronic gout, unspecified wrist, with tophus (tophi)<br>**M1A.1410** Lead-induced chronic gout, right hand, without tophus (tophi)<br>**M1A.1411** Lead-induced chronic gout, right hand, with tophus (tophi)<br>**M1A.1420** Lead-induced chronic gout, left hand, without tophus (tophi)<br>**M1A.1421** Lead-induced chronic gout, left hand, with tophus (tophi)<br>**M1A.1490** Lead-induced chronic gout, unspecified hand, without tophus (tophi)<br>**M1A.1491** Lead-induced chronic gout, unspecified hand, with tophus (tophi)<br>**M1A.1510** Lead-induced chronic gout, right hip, without tophus (tophi)<br>**M1A.1511** Lead-induced chronic gout, right hip, with |

**Table 2: Form CMS-416 EPSDT Reporting Instructions**
**Crosswalk of ICD-9 to ICD-10 Codes for Line 14**
**Total Number of Screening Blood Lead Tests**

| ICD-9 Codes (Form CMS-416) | ICD-10 Codes and Description (for Form CMS-416) effective 10/1/2014 |
|---|---|
| **984.9** Toxic effect of unspecified lead compound<br><br>(continued from prior page) | tophus (tophi)<br>**M1A.1520** Lead-induced chronic gout, left hip, without tophus (tophi)<br>**M1A.1521** Lead-induced chronic gout, left hip, with tophus (tophi)<br>**M1A.1590** Lead-induced chronic gout, unspecified hip, without tophus (tophi)<br>**M1A.1591** Lead-induced chronic gout, unspecified hip, with tophus (tophi)<br>**M1A.1610** Lead-induced chronic gout, right knee, without tophus (tophi)<br>**M1A.1611** Lead-induced chronic gout, right knee, with tophus (tophi)<br>**M1A.1620** Lead-induced chronic gout, left knee, without tophus (tophi)<br>**M1A.1621** Lead-induced chronic gout, left knee, with tophus (tophi)<br>**M1A.1690** Lead-induced chronic gout, unspecified knee, without tophus (tophi)<br>**M1A.1691** Lead-induced chronic gout, unspecified knee, with tophus (tophi)<br>**M1A.1710** Lead-induced chronic gout, right ankle and foot, without tophus (tophi)<br>**M1A.1711** Lead-induced chronic gout, right ankle and foot, with tophus (tophi)<br>**M1A.1720** Lead-induced chronic gout, left ankle and foot, without tophus (tophi)<br>**M1A.1721** Lead-induced chronic gout, left ankle and foot, with tophus (tophi)<br>**M1A.1790** Lead-induced chronic gout, unspecified ankle and foot, without tophus (tophi)<br>**M1A.1791** Lead-induced chronic gout, unspecified ankle and foot, with tophus (tophi)<br>**M1A.18X0** Lead-induced chronic gout, vertebrae, without tophus (tophi)<br>**M1A.18X1** Lead-induced chronic gout, vertebrae, with tophus (tophi)<br>**M1A.19X0** Lead-induced chronic gout, multiple sites, without tophus (tophi) |

## Table 2: Form CMS-416 EPSDT Reporting Instructions
## Crosswalk of ICD-9 to ICD-10 Codes for Line 14
## Total Number of Screening Blood Lead Tests

| ICD-9 Codes (Form CMS-416) | ICD-10 Codes and Description (for Form CMS-416) effective 10/1/2014 |
|---|---|
| **984.9** Toxic effect of unspecified lead compound<br><br>(continued from prior page) | **M1A.19X1** Lead-induced chronic gout, multiple sites, with tophus (tophi)<br>**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter<br>**T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter<br>**T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter<br>**T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter |
| **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 |