Guidance for use of CDT exam codes: D0120, D0150 and D0180
Updated guidance for IHS clinic use: July 28, 2021

Per the ADA CDT (Current Dental Terminology) guide: CDT codes should be used in accordance with what is provided, not based on what insurance will reimburse. The definition and additional guidance for each code should provide the guidance for use:

D0120:
Periodic exam – established patient: Evaluation for a patient of record to determine changes in the patient's dental and medical health status since a previous comprehensive *OR* periodic evaluation.

Includes (must include) a soft tissue (oral cancer) evaluation, periodontal screening where indicated; and *may* require additional interpretation of information (i.e.: interpretation of x-rays, etc.).
JCK Note: Use this code for routine check-up exams

D0150:
Comprehensive Oral Evaluation, new or established patient: This code applies when a general dentist and/or dental specialist examines the patient.
Key components for using D0150:

Can be used for new patient evaluations or evaluations for established patients who have had a significant change in health condition or other unusual circumstances.
Also appropriate for established patients who have been absent from active treatment for three or more years.
This procedure should include:
Recording the extraoral and intraoral hard and soft tissues; evaluation for oral cancer; dental and medical history recording; and a general health assessment.
It MAY include: evaluation and recording of dental caries; missing and/or unerupted teeth; restorations; existing prostheses; occlusal relationships; periodontal conditions, (including periodontal screening and/or charting).
JCK Note: It would not be appropriate to use this code for a routine 6 month checkup exam.

D0180:
Comprehensive periodontal evaluation:
Must include full periodontal charting.

It *may* also include all of the hard and soft tissue evaluation, charting, etc., included in D0120 and D0150.
Therefore, D0180 should not be used on the same visit with either D0120 or D0150.

Dental benefit programs typically have frequency limits for payability of many codes, but that should not be the determinant of how often the procedure code should be used.

However, there are times when common sense influences how codes are included on a claim form.
For example: in one state, for Medicaid claims that are reimbursed at the encounter rate, if the Medicaid claim lists any non-covered or otherwise excluded/unpayable code on the claim form, the entire claim is rejected until a 'clean' claim (with no unpayable codes listed) is submitted. In this scenario, it is logical the benefit program does influence what procedure codes are listed on the claim form. However, this should not be interpreted to justify using an inappropriate code on a claim form or listing a different code in the Clinical Notes.

(Note: there isn't a requirement to list procedure codes in the Clinical Note. However, listing codes recommended for the claim does make coding decisions easier to interpret for coders and billers that may not be familiar with dental coding.)