Coding Corner

Primer on Evaluations Codes

When comparing CDT evaluation codes and assessment, screening, and consultation codes, there are several nomenclatures that seem similar to one another. Some providers struggle in choosing the appropriate code when the nomenclature varies only slightly.

Another consideration to note is which of these evaluation codes are subject to a payer's limitation period and how those restrictions apply.

Payer Limitation Periods

Most plans (plan documents) limit the number of oral evaluations the payer will reimburse during a set period. Generally, these limitations fall under two different categories:

- One evaluation reimbursed every six months
- Two evaluations per twelve months

Payers are firm on these timeframes for both limitation period types. This means that a denial due to a frequency limitation cannot be appealed and any denial will not be reconsidered or overturned. Payers with "one evaluation reimbursed every six months" will only reimburse one evaluation within a given six-month period, and any subsequent evaluations performed during this same six-month limitation period will not be reimbursed. Payers that use a six-month limitation period track it to the day. For example, if an evaluation is completed on July 1, 2021, another evaluation will not be reimbursed until after Jan. 1, 2022.

Unlike the "one evaluation reimbursed every six months," payers who follow the "two evaluations per twelve months" will consider any two evaluations performed during that twelve-month period for reimbursement, even if both evaluations are performed only one day apart.

Both limitations types disallow a third (or more) evaluation during the given timeframe and will not consider any additional evaluations for reimbursement, period, no exceptions. If the dentist deems any additional evaluations necessary, thus exceeding the plan's allowable number of evaluations, there will be no reimbursement. Additionally, if the provider is in network, any "additional" evaluations may be disallowed in some cases and cannot be billed to the patient.

Evaluation Codes

Traditional codes that may describe a first or subsequent patient encounter include D0150, D0180, and D0145:

D0150 Comprehensive oral evaluation – new or established patient

Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

There can be some confusion regarding D0150. Some mistakenly believe this code can only be reported with a new patient. This is likely because many plans have a "once per lifetime" limitation. Although many plans will only reimburse D0150 for a new patient, it may also be used when established patients have had a significant change in their health status or other unusual circumstances, by report, or for established patients who have been absent from active treatment for three or more years. If reporting D0150 for an established patient that meets the criterion established in the description and the claim is denied due to frequency, request an alternate benefit of D0120.

D0180 Comprehensive periodontal evaluation – new or established patient

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.

D0150 and D0180 are similar with a couple of distinct variations. D0150 lists several assessments that "may" be included during the evaluation, particularly the "periodontal screening and/or charting." D0180 states that this comprehensive evaluation may be indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. Code D0180 indicates the evaluation "includes evaluation of periodontal conditions, probing and charting" and mandates the patient has periodontal disease or has risk factors and that periodontal probing and charting be completed.

Confusion arises as to when one can report D0180, mistakenly thinking D0180 may only be reported by a periodontist. However, if the aforementioned criteria are met, a general dentist may report D0180. This code can be submitted for every evaluation performed for the patient with periodontal disease or who has risk factors, if a full periodontal chart is completed in addition to the other necessary services described by D0180. While it might be appropriate to report D0180 at recall to describe this comprehensive periodontal evaluation, some plans may limit the reimbursement of D0180 to once per lifetime. If D0180 is denied, request an alternate benefit of D0120.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver

Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

D0145 describes an oral evaluation for a patient under three years of age. D0145 requires the doctor to record the oral and physical health history, evaluate for caries susceptibility, and develop an appropriate preventive oral health regimen and specifically includes preventive counseling with the child's parent, legal guardian and/or primary caregiver. In the patient's clinical record, the dentist should record and describe what the counseling consisted of. For patients under three years old, D0145 may be reported for the first and any subsequent evaluations until the child reaches the age of 3.

Additional Evaluation Codes

D0120 Periodic oral evaluation – established patient

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

The periodic oral evaluation (D0120) includes "periodontal screening, where indicated." A periodontal screening may be performed at a D0120 visit. This does not mean complete periodontal probing and charting is required at each periodic oral evaluation in order to report the periodic oral evaluation code. There is no separate (stand-alone) code for full mouth periodontal probing and it is included (when performed) in all oral evaluation procedures. Some patients may not need a periodontal screening (e.g., young children or edentulous patients). Additional diagnostic procedures should be reported separately. Although generally not covered by dental plans, it is considered appropriate to bill caries susceptibility tests (D0425), viral cultures (D0416), etc., separately.

D0140 Limited oral evaluation – problem focused

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

Limited oral evaluation – problem focused (D0140) should not be used to report a routine periodic hygiene oral evaluation (D0120); however, should a routine periodic oral evaluation turn into a more complex problem focused evaluation requiring additional diagnostic time, D0140 may be reported.

Reporting a single bitewing (BW) image taken at a D0140 appointment may potentially exhaust the annual "once per year" BWX allowance. Periapical (PA) diagnostic images exposed at the emergency evaluation typically do not count against the annual BWX limitation. PAs are generally considered separate stand-alone procedures. Periapical radiographs may have a deductible, as well as a maximum fee limitation.

Some dentists perform a minor procedure at the emergency visit, but erroneously report this procedure as a problem focused limited oral evaluation (D0140). D0140 is an oral evaluation code, not a treatment code. If a minor procedure was performed due to discomfort, sensitivity, or pain, D9110 (palliative) may be reported.

In some cases, D9110 and D0140 are not reimbursed if reported on the same service date. Likewise, the problem focused oral evaluation D0140 may be denied if reported on the same service date definitive treatment is performed. Sometimes a practice will not report D0140, in order to save the evaluation allowance for a comprehensive oral evaluation (D0150/D0180) or periodic oral evaluation (D0120) visit. This billing/ coding decision is sometimes influenced by the fact that D0150 and D0180 have a higher UCR (usual, customary and reasonable) fee. However, D0140 is a stand-alone code and may be reported in addition to any other treatment procedures rendered on the same service date, i.e., extraction, restoration, or palliative (D9110), etc.,—but remember the reimbursement is subject to the plan's limitations.

D0160 Detailed and extensive oral evaluation – problem focused, by report

A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.

D0160 is intended to describe a problem focused, in depth, comprehensive evaluation of a patient's problem, including more extensive diagnostic modalities that can be used to diagnose and direct treatment to address complex dental conditions. This code describes an evaluation that goes well beyond what could be considered diagnosing and directing care of a simple condition. D0160 should not be considered a routine procedure that follows the D0150/D0180 comprehensive oral evaluation.

D0170 Re-evaluation – limited, problem focused (established patient; not post-operative visit)

Assessing the status of a previously existing condition. For example: A traumatic injury where no treatment was rendered but patient needs follow-up monitoring; evaluation for undiagnosed continuing pain; soft tissue lesion requiring follow-up evaluation.

D0170 describes the re-evaluation of a patient previously seen when a follow-up evaluation is indicated. The patient may have initially presented for a D0150, D0140, D0120, D0180, or D0170, and needs to be seen again for the dentist to arrive at a definitive diagnosis or to confirm/contradict the impression suggested at the previous evaluation. For instance, a follow up to trauma or the further evaluation of a lesion. This would not describe a routine post-op check where the patient had been seen for operative treatment, healing of an extraction, etc.

D0171 Re-evaluation - post-operative office visit

D0171 may be reported when "assessing the status of a previously performed procedure," such as grafts, oral surgery, periodontal surgery, implants, or endodontics which may require a follow-up post-operative visit. In most situations D0171 is a "no charge" follow up visit and is not reported and is considered a global part of the procedure.

Based on the nomenclature language, the re-evaluation – post-operative office visit (D0171) could be reported following definitive treatment (i.e., periodontal, graft, root canal, extraction post-op) or palliative D9110 treatment. The fee for any initial periodontal treatment, such as scaling and root planing (SRP), usually includes any post-operative evaluation associated with said procedure. Likewise, a post-operative (within thirty days) routine evaluation after oral surgery or a root canal would generally be considered inclusive in the global surgery fee.

The nomenclature for D0171 specifically indicates this code reports a post-operative office visit. D0171 could also be used to report a post-operative office visit to check the stability of an implant after placement. D0171 would include the use of technology such as Osstell IDX to check stability. Checking stability as a stand-alone procedure is considered inclusive to the global fee of the implant placement and is not reported as a separate procedure.

All of these evaluation codes are subject to the patient's plan limitation periods for evaluations.

Codes Similar to Evaluations

D0190 Screening of a patient

A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.

These screenings are typically performed by a hygienist or trained ancillary that cannot diagnose but has observed an issue warranting further evaluation by a licensed dentist.

D0191 Assessment of a patient

A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.

D0191 is more detailed than D0190 and may be provided by a dentist or auxiliary individual. D0190 suggests a referral to a dentist is needed should anything of concern be observed during the basic screening. D0191 suggests there is a particular area needing follow up by a licensed dentist.

D0190/D0191: Screenings and Assessments are seldom reimbursed except by some government plans such as Medicaid.

D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

If the purpose of the visit is for a case presentation on a subsequent visit, after the comprehensive evaluation (D0150/D0180), report case presentation (D9450), not consultation (D9310).

Consultation code D9310 should only be reported if the dentist is giving an opinion or advice for a patient specifically referred by a physician, dentist, or other appropriate source (e.g., licensed professional). The consulting dentist may initiate diagnostic and/ or therapeutic services under D9310, which always includes an oral evaluation related to the specific request for the opinion or advice. The dentist should consider reporting D9310 for second opinion requests. The dentist providing the consultation should send (and maintain a copy of) written communication to the referring dentist or physician about his/her findings during the consultation.

If the purpose of the visit is to provide a second opinion, at the patient's request—not at the request of a dentist or physician—report D0140 (oral evaluation, problem focused) for a particular patient complaint or report D0150/D0180 (comprehensive evaluation) for a general second opinion. The self-referred patient is classified as a new patient and the appropriate traditional comprehensive oral evaluation should be reported, not D9310, which specifically requires a referral from a dentist, physician, or another appropriate source.

D9450 Case presentation, detailed and extensive treatment planning

Established patient. Not performed on same day as evaluation.

D9450 describes the scenario when a patient is evaluated at one appointment, then returns for a detailed treatment plan presentation at a subsequent appointment. A case presentation is rarely reimbursed by payers and is typically considered part of the original oral evaluation service. Do not report D9450 for an evaluation of self-referred patients.

When selecting the proper code to describe an evaluation and any related service, it is important to understand how each of these evaluation codes differ and how to select the proper code based on these differences.

It is also important to note that the period limitations established by payers that may directly affect reimbursement. Any evaluation type is considered "one" evaluation from the payer's perspective in terms of reimbursement. Also, remember every oral evaluation will be subject to either the "one evaluation reimbursed every six months" or "two evaluations per twelve months" limitation.

For questions or comments, please contact Dental Benefits Director Mary Essling at *messling@aapd.org*.

AAPD Releases New Guidance on the Use of CDT 2021 Code D1355

With the release of the CDT-2021 dental coding manual on Jan. 1, 2021, the CDT code **D1355 – caries preventive medicament application, per tooth** – was approved. A recent analysis by experts from the AAPD's Councils on Clinical and Scientific Affairs, and Committee on Dental Benefit Programs concluded that, although Silver Diamine Fluoride **(SDF)** has proven efficacy as a secondary preventive agent (i.e., arrest of carious lesions) in numerous clinical studies, evidence of its efficacy as a primary preventive agent on children is insufficient at present. Therefore, without solid scientific evidence, the AAPD does not support the use of the code D1355 for use of SDF as a primary preventive agent in children. Accordingly, the AAPD recommends D1354 as the appropriate code for SDF when used as a caries arresting agent on cavitated carious lesions in primary teeth.