Oral Surgery: Non-Pathologic Excisional Procedures

Guideline Number: DCG029.10
Effective Date: October 1, 2023

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Related Dental Policies

- Fixed Prosthodontics
- Medically Necessary Orthodontic Treatment
- Oral Surgery: Alveoloplasty and Vestibuloplasty
- Oral Surgery: Miscellaneous Procedures
- Removable Prosthodontics

Coverage Rationale

Frenulectomy/Frenuloplasty
Frenulectomy and Frenuloplasty are indicated for the following:
- When attachment of the Frenum is coronal to the mucogingival junction, within the free gingiva, or in the papilla causing a diastema, gingival recession, or stripping
- When the position attachment of the Frenum is interfering with proper oral hygiene
- Prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech
- For Ankyloglossia or papillary penetrating attachment of maxillary labial Frenum in newborns when there is interference with feeding

Excision of Hyperplastic Tissue and Surgical Reduction of Fibrous Tuberosity
Excision of Hyperplastic tissue and surgical reduction of a fibrous Tuberosity is indicated when the presence of excess tissue interferes with the fit of a partial or complete denture (existing or new).

Excision of Pericoronal Gingiva
Excision of pericoronal gingiva is indicated for the following:
- For recurrent infections of the operculum around impacted or partially erupted lower third molars
- When an erupted maxillary third molar is traumatizing soft tissue around opposing tooth
- When the presence interferes with the fit of a partial or complete denture

Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report
Transseptal fiberotomy-supra crestal fiberotomy is indicated to reduce rotational relapse of individual teeth following orthodontic treatment.

Removal of Lateral Exostosis (Maxilla or Mandible), Torus Palatinus and Torus Mandibularis
Removal of lateral Exostoses, Torus Palatinus and Torus Mandibularis is indicated for the following:
- If a partial or complete denture cannot be adapted successfully
- When causing soft tissue trauma with existing removable appliances
For unusually large protuberances that are prone to recurrent traumatic injury
When there is a functional disturbance, including, but not limited to mastication, swallowing and speech

Bony excisional procedures are not indicated for patients with unmanaged medical conditions that result in excessive or uncontrolled bleeding, reduced resistance to infection, or poor healing response.

Definitions

Ankyloglossia: Partial or complete fusion of the tongue with the floor of the mouth or the lingual gingiva due to an abnormally short, mid-line lingual Frenulum, resulting in restricted tongue movement (also known as tongue-tie). (AAP)

Exostosis/Exostoses: A benign, bony growth projecting outward from the surface of a bone. (AAP)

Frenum/Frenulum: A fold of mucous membrane tissue that attaches the lips and cheeks to the alveolar mucosa (and/or gingiva) and underlying periosteum. (AAP)

The Placek’s Classification of Labial Frenal Attachments (Devishee et. al):

- Mucosal: When the frenal fibres are attached up to the mucogingival junction
- Gingival: When the fibres are inserted within the attached gingiva
- Papillary: When the fibres are extending into the interdental papilla
- Papilla Penetrating: When the frenal fibres cross the alveolar process and extend up to the palatine papilla

Hyperplastic: The increase in the size of a structure due to an increase in the number of cells. (AAP)

Torus Palatinus: A bony protuberance occurring at the midline of the hard palate. (AAP)

Torus Mandibularis: A bony exostosis on the lingual aspect of the mandible, generally in the premolar-molar region; commonly bilateral. (AAP)

Tuberosity: An osseous projection or protuberance. (AAP)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D7291</td>
<td>Transseptal fiberotomy/ supra crestal fiberotomy, by report</td>
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<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
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<td>D7472</td>
<td>Removal of torus palatinus</td>
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<td>D7473</td>
<td>Removal of torus mandibularis</td>
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<tr>
<td>D7961</td>
<td>Buccal / labial frenectomy (frenulectomy)</td>
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<tr>
<td>D7962</td>
<td>Lingual frenectomy (frenulectomy)</td>
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<tr>
<td>D7963</td>
<td>Frenuoplasty</td>
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<tr>
<td>D7970</td>
<td>Excision of hyperplastic tissue – per arch</td>
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<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
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<tr>
<td>D7972</td>
<td>Surgical reduction of fibrous tuberosity</td>
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<tr>
<td>D7999</td>
<td>Unspecified oral surgery procedure, by report</td>
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### Description of Services

Oral surgery excisional procedures involve the removal and/or alteration of hard and soft oral tissues to achieve normal physiologic function or allow the proper fit of removable appliances.

Pursuant to CA AB2585: While not common in dentistry, nonpharmacological pain management strategies should be encouraged if appropriate.

### References

- American Academy of Periodontology (AAP) Glossary of Periodontal Terms.
- American Dental Association (ADA) CDT Codebook 2023.
- American Dental Association Glossary of Clinical and Administrative Terms.

### Guideline History/Revision Information

<table>
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<tr>
<th>Date</th>
<th>Summary of Changes</th>
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<tr>
<td>10/01/2023</td>
<td><strong>Coverage Rationale</strong></td>
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<tr>
<td></td>
<td>● Removed content addressing coverage limitations and exclusions</td>
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Instructions for Use

This Dental Coverage Guideline provides assistance in interpreting UnitedHealthcare standard dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard dental plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Dental Coverage Guideline is provided for informational purposes. It does not constitute medical advice.