

ORAL SURGERY: NON-PATHOLOGIC EXCISIONAL PROCEDURES

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Related Dental Policies
<ul style="list-style-type: none"> • Fixed Prosthodontics • Medically Necessary Orthodontic Treatment • Oral Surgery: Alveoplasty and Vestibuloplasty • Oral Surgery: Miscellaneous Procedures • Removable Prosthodontics

INSTRUCTIONS FOR USE

This Dental Coverage Guideline provides assistance in interpreting UnitedHealthcare dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Dental Coverage Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Dental Coverage Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Dental Coverage Guideline. Other Clinical Policies and Coverage Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Dental Coverage Guideline is provided for informational purposes. It does not constitute medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group health plans (inside and outside of Exchanges) to provide coverage for Pediatric Dental Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for Pediatric Dental EHBs. However, if such plans choose to provide coverage for benefits which are deemed Pediatric Dental EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute Pediatric Dental EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Frenulectomy

Frenulectomy is 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 frenum attachment
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech
- For ankyloglossia or severe papillary penetrating attachment of maxillary labial frenum in newborns when there is interference with feeding

Frenuloplasty

Frenuloplasty is 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 and its depth or width requires surgical restoration of physiologic function
- 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 severe papillary penetrating attachment of maxillary labial frenum in newborns when there is interference with feeding

Excision of Hyperplastic Tissue – Per Arch

Excision of hyperplastic tissue is indicated when the presence of hyperplastic tissue (fibrous tuberosities, loose ridges, folds of redundant tissues in vestibule or floor of mouth, and palatal papillomatosis) 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

Surgical Reduction of Fibrous Tuberosity

Surgical reduction of fibrous tuberosity is indicated 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)

Removal of lateral exostosis is indicated for the following:

- If a partial or complete denture cannot be adapted successfully to the alveolar ridge
- When causing soft tissue trauma with existing removable appliances
- For unusually large exostoses that are prone to recurrent traumatic injury

Removal of lateral exostosis is not indicated for patients with unmanaged medical conditions that result in excessive bleeding, reduced resistance to infection, or poor healing response.

Removal of Torus Palatinus

Removal of torus palatinus is indicated for the following:

- When a dental prosthesis will cover the palate and a large palatal torus will interfere with fit
- For unusually large tori that are prone to recurrent traumatic injury
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech

Removal of torus palatinus is not indicated for patients with unmanaged medical conditions that result in excessive or uncontrolled bleeding, reduced resistance to infection, or poor healing response.

Removal of Torus Mandibularis

Removal of torus mandibularis is indicated for the following:

- If a mandibular partial or complete denture cannot be adapted successfully to the alveolar ridge
- For unusually large tori that are prone to recurrent traumatic injury
- When the tori is so large that it interferes with normal tongue movement
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech

Removal of torus mandibularis is not indicated for patients with unmanaged medical conditions that result in excessive or uncontrolled bleeding, reduced resistance to infection, or poor healing response.

Coverage Limitations and Exclusions

The following are excluded from coverage:

- Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any dental procedure performed solely for cosmetic/aesthetic reasons (cosmetic procedures are those procedures that improve physical appearance).

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 (Devishree 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 premolarmolar 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 Clinical Policies and Coverage Guidelines may apply.

CDT Code	Description
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue – per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity
D7999	Unspecified oral surgery procedure, by report

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CPT Code	Description
21031	Excision of torus mandibularis
21032	Excision of maxillary torus palatinus
40806	Incision of labial frenum (frenotomy)

CPT Code	Description
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
41010	Incision of lingual frenum (frenotomy)
41115	Excision of lingual frenum (frenectomy)
41520	Frenoplasty (surgical revision of frenum, e.g., with Z-plasty)
41821	Operculectomy, excision pericoronal tissues
41822	Excision of fibrous tuberosities, dentoalveolar structures
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)

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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. They may be done with scalpels, lasers or electrosurgery and related post-operative follow up care is considered inclusive. Procedures related to transplant preparation (including the initiation of immunosuppressives), traumatic injury and accidental dental and for the treatment of cancer & cleft lip/palate are medical in nature and are typically covered under a member's medical plan. Please refer to the member specific benefit plan document.

REFERENCES

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Takei E, Scheyer T, Azzi R, et al. Carranza's Clinical Periodontology, 12th ed. St. Louis: Mosby c2015. Chapter 63, Periodontal Plastic and Esthetic Surgery; p. 628-631.

UnitedHealthcare Insurance Company Dental Certificate of Coverage 2012.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	<ul style="list-style-type: none"> Revised coverage rationale/coverage limitations and exclusions; removed language indicating frenulectomy and frenuloplasty are considered incidental if performed on the same day, same area as gingivectomy/gingivoplasty, alveoloplasty and vestibuloplasty surgical procedures Updated supporting information to reflect the most current references Archived previous policy version DCG029.02