MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**Dental and Oral Care under Medical Plans**
Policy Number	**7.01.21**
Category	**Contract Clarification**
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Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Oral surgical procedures are **ineligible for coverage** under the medical portion of a member's subscriber contract, unless otherwise stated. Oral surgical procedures may include, but are not limited to: dental extractions, periodontal treatment, or biopsies for dental related cysts or tissue of dental origin (e.g., amalgam tattoo, fibroma, or hyperkeratoses).

II. Developmental Cysts:
   A. Developmental cysts of epithelial remnants (e.g., globulomaxillary cysts, median alveolar cysts, median palatine cysts, nasopalatine cysts) are not tooth-related. Removal of these cysts is considered **medically appropriate** under medical/surgical contracts, subject to the terms of the member's subscriber contract.

   B. Removal of tooth-related cysts (e.g., follicular-dentigerous, primordial, or multilocular-cysts, cysts of mallassez, radicular cysts, residual cysts, and odontomas) is considered **medically appropriate** under dental contracts; dental benefits are contract-specific. The removal of tooth-related cysts is **ineligible for coverage** as a medical/surgical benefit.

III. A biopsy of the buccal mucosa, tongue, palate or floor of the mouth is considered **medically appropriate** under medical/surgical contracts; benefits are contract specific.

IV. A biopsy of the gingiva or supporting structures of the teeth is a medical procedure and is considered **medically appropriate** under medical/surgical contracts, unless tissue was obtained as part of a routine tooth extraction or a routine periodontal procedure. If the biopsy reveals only a dental condition, subsequent care or treatment of that condition is **ineligible for coverage** under medical/ surgical contracts, unless otherwise stated.

V. X-rays, including cone beam imaging for implant placement (CT scans), are **ineligible for coverage** under the medical benefit of a member's subscriber contract, unless otherwise stated.

VI. Accidental injury to sound, natural teeth: An accidental injury is defined as a "blow to the face" and does not include biting injuries. Services for the treatment of an accidental injury to sound, natural teeth, when rendered within 12 months from the date of injury, are **eligible for coverage** in accordance with the benefits set forth in the member's medical/surgical contract, provided that the tooth is sound and natural, with no restorative treatment and no disease prior to the injury. A sound tooth is one sufficiently supported by its natural structure (bone and gum tissue) that was formed by the human body and is not decayed or weakened by previous dental work at the injury site (for example, a tooth with no crown, root canal, periodontal condition, or fracture that is not in need of treatment for any reason other than the accidental injury).

Coverage under the medical/surgical contract will only be provided for services that:

A. Fall within a category of services for which there is a benefit provided under the member's subscriber contract;
B. Deemed medically necessary according to the criteria set forth in Corporate Medical Policy #11.01.15, which addresses Medically Necessary Services, and
C. Rendered within 12 months of an accidental injury.

Exceptions to the 12-month time frame are not granted for the staging of procedures.

VII. Congenital anomaly or disease: Services for the treatment of a congenital anomaly or disease are **eligible for coverage** under the member's medical/surgical contract in accordance with the benefits set forth in the contract when:

A. The services are for the treatment of an underlying congenital anomaly or disease that was present at birth, and medical documentation of the anomaly is provided (e.g., genetic testing records, birth defects). Congenital anomaly or disease is defined as an abnormality of structure or function that was present at birth (e.g., cleft palate, ectodermal dysplasia, ankyloglossia). A clinical condition that develops after birth but is based on inherited factors (e.g., diabetes) is not considered congenital.

1. Coverage under the medical/surgical contract will only be provided for *frenectomy (CPT code 41115), frenotomy (CPT code 41010)* or *frenoplasty (CPT code 41520)* of the lingual frenum related to congenital ankyloglossia, when the ankyloglossia restricts the movement of the tongue leading to problems with newborn feeding, and speech in children.

2. Based upon the literature and/or available information, *frenectomy (CPT code 41115), frenotomy (CPT code 41010),* and *frenoplasty (CPT code 41520)* of the lingual frenum are considered **not medically necessary** when performed prophylactically to promote speech development in children or adults, because the effectiveness of this approach has not been established.

B. Coverage under the medical/surgical contract will only be provided for services that fall within a category of services for which there is a benefit provided under the member's subscriber contract which are considered **medically necessary** according to the criteria set forth in Corporate Medical Policy #11.01.15, which addresses Medically Necessary Services.

VIII. All other dental services rendered by a dental provider (e.g., DMD, DDS) are **ineligible for coverage** under the member's medical/surgical contract, unless otherwise stated.

Refer to Corporate Medical Policy #7.03.01 Coverage for Ambulatory Surgery Unit (ASU) and Anesthesia for Dental Services.

Refer to Corporate Medical Policy #11.01.15 Medically Necessary Services.

Refer to Corporate Medical Policy #13.01.01 Dental Implants.

Refer to Corporate Medical Policy #13.01.02 Dental Crowns and Veneers.

Refer to Corporate Medical Policy #13.01.03 Dental Inlays and Onlays.

Refer to Corporate Medical Policy #13.01.04 Periodontal Scaling and Root Planing.

Refer to Corporate Medical Policy #13.01.05 Periodontal Maintenance.

POLICY GUIDELINE

Refer to the member's subscriber contract for specific benefit eligibility.

DESCRIPTION

Oral surgery involves the correction of conditions of or damage to the mouth, teeth, and jaw. Oral surgery is commonly performed to remove wisdom teeth, prepare the mouth for dentures, repair jaw conditions, and perform more advanced procedures, as required after trauma or severe disease damage to the structure of the mouth.

There are two categories of dentoalveolar bone cysts which include cysts arising from epithelial remnants (developmental) and cysts arising from dental tissue.

Routine dental procedures, which are not covered under medical/surgical contracts, include, but are not limited to:

I. Correction of impactions;
II. Endodontic therapy;
III. Extraction of teeth;
    a. Implant placement;
    b. Oral biopsies with a dental diagnosis;
    c. Periodontal treatment;
    d. Placement of fillings;
    e. Preventive care;
    f. Prosthetics;
    g. Sedation; and
    h. X-rays.

Congenital Anomalies are defined by the World Health Organization as birth defects, congenital disorders or congenital malformations. Congenital anomalies can be defined as structural or functional anomalies (for example, metabolic disorders) that occur during intrauterine life and can be identified prenatally, at birth, or sometimes may only be detected later in infancy, such as hearing defects. In simple terms, congenital refers to the existence at or before birth.

Ankyloglossia, also known as tongue tie, identifies conditions ranging in severity from a malposition of the frenulum on the underside of the tongue (lingual frenum) to partial or total fusion of the tongue to the floor of the mouth. Normally the frenulum does not impede the movement of the tip of the tongue but when the frenulum is too short or attaches close to the tip of the tongue, it restricts the movement of the tongue and may cause difficulty with feeding in infants and speech development in children.

Frenectomy for congential ankyloglossia is a surgical procedure that removes the lingual frenum of the tongue. This differs from frenotomy for *congential ankyloglossia*, where the frenum is simply incised and not removed. *Frenoplasty* for congential ankyloglossia, is the surgical revision of lingual frenum with Z-plasty. All three procedures are performed under local anesthesia and result in greater range of motion of the tongue.

RATIONALE

There is some evidence to suggest that frenotomy, frenectomy or frenoplasty may be associated with improvements in breastfeeding in infants or in promoting subsequent speech development in infants and children. However, studies are small, without long-term outcomes, heterogeneous, and inconsistent. Additional studies are needed to determine the optimal timing of frenotomy and the ideal screening tool to detect significant ankyloglossia.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
41010	Incision of lingual frenum (frenotomy); (Please refer to Policy Statement VII)
41115	Excision of lingual frenum (frenectomy); (Please refer to Policy Statement VII)
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty); (Please refer to Policy Statement VII)
Several Other Codes	

HCPCS Codes

Code	Description
Several Codes	

ICD10 Codes

Code	Description
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.7	Cleft uvula
Q35.9	Cleft palate, unspecified
Q37.0	Cleft hard palate with bilateral cleft lip
Q37.1	Cleft hard palate with unilateral cleft lip
Q37.2	Cleft soft palate with bilateral cleft lip
Q37.3	Cleft soft palate with unilateral cleft lip
Q37.4	Cleft hard and soft palate with bilateral cleft lip
Q37.5	Cleft hard and soft palate with unilateral cleft lip
Q37.8	Unspecified cleft palate with bilateral cleft lip
Q37.9	Unspecified cleft palate with unilateral cleft lip
Q38.1	Ankyloglossia
Q38.5	Congenital malformations of palate, not elsewhere classified
Q82.4	Ectodermal dysplasia (anhidrotic)
Several Other Codes	

CDT Codes

Code	Description
Refer to the ADA Current Dental Terminology Manual	

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*Key Article

KEY WORDS

Dental cysts, Frenectomy, Frenotomy, Frenuloplasty, Frenoplasty, Odontogenic cysts, Radicular cysts, Oral surgery.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based on our review, Oral Surgery is not addressed in National or Regional Medicare coverage determinations or policies. However, there is an overview of Medicare Dental Coverage for Medicare members that can be viewed at: [https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index?redirect=/MedicareDentalCoverage/]