MEDICAL POLICY

Medical Policy Title	**Dental and Oral Care under Medical Plans**
Policy Number	**7.01.21**
Current Effective Date	**May 21, 2026**
Next Review Date	**May 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

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).

I. 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.

C. The removal of tooth-related cysts is **ineligible for coverage** as a medical/surgical benefit.

II. Oral Biopsies

A. 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.

B. 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.

C. If the biopsy reveals only a dental condition, then subsequent care or treatment of that condition is **ineligible for coverage** under medical/ surgical contracts, unless otherwise stated.

III. 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 include **ALL** of the following criteria:

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.

(*Please note that exceptions to the 12-month time frame are not granted for the staging of procedures.)

IV. 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 or correction of functional impairment 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).

   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 articulation in children.

   2. 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/articulation 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 in accordance with the criteria set forth in Corporate Medical Policy #11.01.15 Medically Necessary Services.

RELATED POLICIES

Corporate Medical Policy

7.03.01 Coverage for Ambulatory Surgery Unit (ASU)/ Outpatient Facility and Anesthesia for Dental Services

11.01.15 Medically Necessary Services

13.01.01 Dental Implants

13.01.02 Dental Crowns and Veneers

13.01.03 Dental Inlays and Onlays

13.01.04 Periodontal Scaling and Root Planing

13.01.05 Periodontal Maintenance

POLICY GUIDELINE(S)

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

II. All other dental services rendered by a dental provider (e.g., Doctor of Medical Dentistry, Doctor of Dental Surgery) not listed in the above Policy Statements are **ineligible for coverage** under the member's medical/surgical contract, unless otherwise stated.

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. Developmental cysts of epithelial remnants (e.g., globulomaxillary cysts, median alveolar cysts, median palatine cysts, nasopalatine cysts) are not tooth-related. Examples of cysts arising from dental tissue (tooth-related) include follicular-dentigerous, primordial, or multilocular-cysts, cysts of mallassez, radicular cysts, residual cysts, and odontomas.

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.

Accidental Injury to Teeth

Trauma involving the dento-alveolar region is a frequent occurrence which can result in the fracture and displacement of teeth, crushing, and/or fracturing of bone, and soft tissue injuries including contusions, abrasions, and lacerations. Traumatic dental injuries (TDIs) of permanent teeth occur most frequently in children, young adults and elderly persons. Crown fractures and luxations of these teeth are the most commonly occurring of all dental injuries. Proper diagnosis, treatment planning, and follow up are important for achieving a favorable outcome.

Congenital Anomalies

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. A clinical condition that develops after birth but is based on inherited factors (e.g., diabetes) is not considered congenital.

Ankyloglossia

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.

Various grading tools exist to assist practitioners with diagnosing ankyloglossia. The Coryllos classification tool is useful to determine the type of frenulum, but it does not include the evaluation of function nor a criterion for ankyloglossia. The Hazelbaker Assessment Tool for Lingual Frenulum Function (HATLFF) assesses both frenulum anatomy and function and scores ankyloglossia. Regardless of the evaluation tool used, it is essential to demonstrate restricted tongue movement and ascertain that the lingual frenulum exclusively causes this limitation.

Frenectomy for Congenital Ankyloglossia

Frenectomy for congenital ankyloglossia is a surgical procedure that removes the lingual frenum of the tongue. This differs from frenotomy for congenital ankyloglossia, where the frenum is simply incised and not removed. Frenoplasty for congenital 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.

SUPPORTIVE LITERATURE

The published literature on ankyloglossia and its treatment is large and diverse and provides conflicting evidence due to many studies lacking appropriate control groups, and lacking systematic measurement of outcomes. There is clinical evidence to suggest that frenotomy, frenectomy or frenoplasty is associated with improvements in breastfeeding in infants or in promoting subsequent speech development in infants and children.

Bruney and colleagues (2022) performed a systematic review and meta-analysis of a total of six (6) studies (four randomized and two non-randomized) involving breastfeeding interventions for full-term infants to examine the effectiveness of ankyloglossia treatment on breastfeeding difficulties. The study sample sizes ranged from 25 to 107 mother–infant dyads, which totaled 329. The meta-analysis of standardized mean differences in breastfeeding difficulty scores in four studies showed statistically significant differences in favor of frenotomy (Pooled SMD +2.12, CI:(0.17–4.08) p = 0.03). Similarly, a statistically significant difference in favor of frenotomy was observed for pain (Pooled SMD −1.68, 95% CI: (−2.87 to−0.48). The authors concluded that infant frenotomy is effective for improving standardized scores on breastfeeding difficulty and maternal pain scales. However, future trials should also include longer-term follow-up, to determine whether observed improvements immediately following frenotomy increase the likelihood of achieving the WHO recommendations of at least six (6) months of exclusive breastfeeding.

PROFESSIONAL GUIDELINE(S)

There is no uniformity of an accepted diagnostic criteria for ankyloglossia by professional societies. There is also a lack of consensus for treatment of ankyloglossia, leading to wide practice variation in the United States and internationally.

REGULATORY STATUS

New York Insurance Law § 3217: The law provides allowable exclusions in such policies and contracts as set forth in N.Y. Comp. Codes R. & Regs. Tit, 11, § 52.16(c) (2002): (9) dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).

- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

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

HCPCS Codes

Code	Description
Multiple Codes	

ICD10 Codes

Code	Description
P92.2	Slow feeding of newborn
P92.3	Underfeeding of newborn
P92.4	Overfeeding of newborn
P92.5	Neonatal difficulty in feeding at breast
P92.6	Failure to thrive in newborn
P92.8	Other feeding problems of newborn
P92.9	Feeding problem of newborn, unspecified
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

Code	Description
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)
Multiple Other Codes	

REFERENCES

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Bourguignon C, et al. International Association of Dental Traumatology guidelines for the management of traumatic dental injuries: fractures and luxations. Dent Traumatol. 2020;36(4):314-330.

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Chowdhry R, et al. Alternative therapies for ankyloglossia-associated breastfeeding challenges: a systematic review. Breastfeed Med. 2024 Apr 9. doi:10.1089/bfm.2024.0072. Online ahead of print.

Cordray H, et al. Quantitative impact of frenotomy on breastfeeding: A systematic review and meta-analysis. Pediatr Res. 2024 Jan;95(1):34-42.

Garrido MDPG, et al. Effectiveness of myofunctional therapy in ankyloglossia: A systematic review. Int J Environ Res Public Health. 2022;19(19):12347.

Thomas J, et al. Identification and management of ankyloglossia and its effect on breastfeeding in infants: clinical report. Pediatrics. 2024 Aug;154(2):e2024067605.

Wang J, et al. The effect of ankyloglossia and tongue-tie division on speech articulation: A systematic review. Int J Paediatr Dent. 2022;32(2):144-156.

SEARCH TERMS

Odontogenic cysts

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Oral Surgery is not addressed in National or Regional Medicare coverage determinations or policies. Please refer to the Medicare Dental Coverage Guidance [Last updated 2025 Jan 3; accessed 2026 Apr 21] Available from: Medicare Dental Coverage

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, 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 HISTORY/REVISION

Committee Approval Dates

10/18/01, 01/24/02, 02/27/03, 02/26/04, 09/28/05, 12/07/06, 12/13/07, 12/11/08, 12/10/09, 10/28/10, 06/24/11, 06/28/12, 06/27/13, 06/26/14, 04/23/15, 04/28/16, 04/27/17, 06/28/18, 06/27/19, 06/25/20, 06/24/21, 06/16/22, 06/22/23, 05/16/24, 05/22/25, 05/21/26

Date	Summary of Changes
05/21/26	• Annual review; policy intent unchanged
01/14/26	• Policy Edit: Format Correction
05/22/25	• Annual Review; policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.

10/18/01	• Original effective date