Dental Clinical Policy: Frenectomy (Frenulectomy)

Reference Number: CP.DP.41
Last Review Date: 12/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Frenectomy (frenulectomy) or frenuloplasty involves the surgical release and/or repositioning of soft tissue fibers attached to maxillary labial/buccal alveolar mucosa and gingival tissue, the tongue and mandibular lingual alveolar mucosa or gingival tissue, or mandibular labial/buccal alveolar mucosa and gingival tissue.

Policy/Criteria

I. It is the policy of Centene Dental Services™ that frenectomy (frenulectomy) or frenuloplasty is **medically necessary** when any of the following conditions are met:

- **A.** When the frenum attachment is diagnosed by a physician as the primary cause of infant breastfeeding/suckling difficulty;
- **B.** When the frenum attachment impedes proper fit or causes tissue trauma related to a removable prosthesis;
- **C.** When the frenum attachment interferes with proper oral hygiene measures;
- **D.** When the frenum attachment interferes with proper placement and/or seating of dental restorations;
- **E.** When the frenum attachment poses the potential for orthodontic treatment relapse;
- **F.** When the frenum attachment creates a significant persistent midline diastema and results in a physician-diagnosed and medically documented psychological condition;
- **G.** When the frenum attachment causes gingival defects and/or loss of alveolar bone leading to a present or future detriment of the involved dento-alveolar complex;
- **H.** When the frenum attachment limits tongue mobility/function and creates a physician-diagnosed and medically documented restriction:
- **I.** When the frenum attachment results in physician or speech pathologist-diagnosed speech pathology;
- **J.** When the frenum attachment causes physician-diagnosed swallowing problems;
- **K.** Does not have any of the following contraindications:
    1. When the frenectomy (frenulectomy) or frenuloplasty is provided solely for cosmetic reasons/purposes;
    2. When the frenectomy (frenulectomy) or frenuloplasty is provided during the primary dentition to reduce or eliminate natural spacing between primary teeth;
    3. When the frenum attachment is in close proximity to vasculature and nervous structures and treatment poses the risk of permanent damage to nervous/vascular tissues during the incision and drainage process;
    4. When health conditions are present that could potentially affect soft tissue healing (Severe Ehlers-Danlos Syndrome, chemotherapy agents, etc.);
- **L.** Required documentation to support medical necessity include the following:
    1. Clinical chart, treatment notes, and physician or speech pathologist records, as well as lactation consultant records when requested, documenting conditions listed in the indications for the use of frenectomy or frenuloplasty;
    2. Photographic images showing the frenum condition, when requested.

II. Coverage Limitation/Exclusions

1. One D7961 or D7963 per arch per lifetime
2. One D7962 per lifetime
3. Subject to state-specific regulations.

Coding Implications

This clinical policy references Current Dental Terminology (CDT®). CDT® is a registered trademark of the American Dental Association. All CDT codes and descriptions are copyrighted 2024, American Dental Association. All rights reserved. CDT codes and CDT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Retrospective review/analysis or fraud, waste and abuse initiatives that identify mis-coding (upcoding) resulting in higher reimbursement than allowed for the correctly coded service, or does not provide documentation supporting performing and/or completing claimed services may result in the recoupment of the identified monetary variance by any of the following means: a) from the payment for other claimed services; or b) directly from the provider.

CDT® Codes	Description
D7961	Buccal / labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty – excision of frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M26.01	Maxillary hyperplasia
M26.03	Mandibular hyperplasia
M26.71	Alveolar maxillary hyperplasia
M26.72	Alveolar mandibular hyperplasia
M26.79	Other unspecified alveolar anomalies
M26.81	Anterior soft tissue impingement
M26.82	Posterior soft tissue impingement
M26.82	Posterior soft tissue impingement
Q38.0	Congenital malformations of lips, not elsewhere classified
Q38.1	Ankyloglossia
Q38.3	Other congenital malformations of tongue
Q38.6	Other congenital malformations of mouth
R47.9	Unspecified speech disturbances
F80.9	Developmental disorders of speech and language, unspecified

ICD-10-CM Code	Description
K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8	Other specified orders of gingiva and edentulous alveolar ridge

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	10/20	10/20
Annual Review	11/21	11/21
Annual Review	12/22	12/22
Annual Review and Format Change	12/23	12/23
Policy Revision	4/24	4/24
Annual Review	12/24	12/24

References

1. American Dental Association. CDT 2024: Dental Procedure Codes. American Dental Association, 2024.
2. American Academy of Pediatric Dentistry. Pediatric Dentistry: Reference Manual. 2022.
3. Hupp, J., Tucker, M., & Ellis, E. (2018). Contemporary Oral and Maxillofacial Surgery. St. Louis, Mo: Mosby Elsevier.
4. Ness G. (2016). Atlas of Oral and Maxillofacial Surgery, 1st ed. St. Louis, Mo: Mosby Elsevier.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Centene Dental Services makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. “Centene Dental” means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Dental and Visions Services, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Centene Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Centene Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Centene Dental retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care, and are solely responsible for the dental and medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom Centene Dental has no control or right of control. Providers are not agents or employees of Centene Dental.

This clinical policy is the property of Centene Dental. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at https://www.cms.gov/ for additional information.