Delta Dental of Michigan Clinical Criteria for Utilization Management Decisions				
Reference Number: 282.38	Title: Clinical Criteria for Frenectomy and Frenuloplasty			
Issue Date (Effective Date): 2/28/2025	Next Review Date: 8/1/2025	Last Review Date: N/A (Initial Version)	Last Revised Date: N/A (Initial Version)	UM Committee Approval Date: 2/28/2025

Introduction

This Delta Dental of Michigan (Delta Dental) clinical criteria document addresses frenectomy (frenulectomy) and frenuloplasty treatment. The purpose of this document is to provide written clinical criteria to ensure that Delta Dental consistently applies sound and objective clinical evidence when determining the medical necessity and clinical appropriateness of frenectomy and frenuloplasty, as well as taking individual patient circumstances and the local delivery system into account.

Oral frenulums are thin folds of intraoral mucosal tissue containing muscle and connective tissue fibers that serve as attachments between the lip/cheek and alveolar mucosa, gingiva or underlying periosteum. Oral frenulums include the maxillary labial frenulum generally connecting the upper lip and mucosal/gingival tissues, the mandibular labial frenulum generally connecting the lower lip and mucosal/gingival tissues and the lingual frenulum extending from the underside of the tongue to the floor of the mouth. When an oral frenulum is adversely positioned, it can negatively affect speaking, taking nourishment, periodontal health, tooth eruption and positioning, the stability of orthodontic treatment or placement of a restoration or prosthetic appliance.

In clinical situations where an adversely positioned oral frenulum is having a negative impact on an individual's oral and/or systemic health, frenectomy or frenuloplasty surgery may be employed to remove or release and reposition the frenulum. Frenectomy/frenulectomy involves the complete removal of an oral frenulum including any underlying bone attachment. Frenuloplasty involves frenulum excision accompanied by excision or repositioning of aberrant muscle and z-plasty or other local flap closure. These procedures may be performed utilizing conventional scalpel technique, electrosurgery or laser surgery. The use of a laser or electrocautery device generally involves less risk and better patient compliance.

Frenectomy and frenuloplasty treatment is commonly performed by general dentists and dental specialists in a variety of healthcare facilities, often following referral by medical professionals and specialists (e.g., otolaryngologists).

Applicable Dental Procedure Codes

The following dental procedure codes defined in the current version of the American Dental Association's Code on Dental Procedures and Nomenclature (the CDT® Code) are applicable to this document and are the appropriate codes to use when documenting the performance of frenectomy and frenuloplasty treatment. Inclusion of these codes here is for informational purposes only and does not imply benefit coverage or noncoverage of a procedure by a member's dental plan. A determination that a dental procedure is medically necessary and clinically appropriate does not guarantee that the procedure is a covered benefit of a member's dental plan. To determine if frenectomy and frenuloplasty are a covered benefit of an individual member's dental plan, please refer to the plan documents in effect on the date of service.

CDT® Procedure Code	Procedure Code Nomenclature
D7961	buccal / labial frenectomy (frenulectomy)
D7962	lingual frenectomy (frenulectomy)
D7963	frenuloplasty

Clinical Criteria[1]

When approval of benefit payment for frenectomy or frenuloplasty by a member's dental plan requires a determination by Delta Dental that the frenectomy or frenuloplasty treatment is medically necessary and clinically appropriate, the patient's dental record must document a diagnosis by a qualified health professional of a dental or medical condition where frenectomy or frenuloplasty is a generally accepted treatment. When attributable to adverse positioning of a frenulum attachment, the following conditions are considered to be indications for performing frenectomy or frenuloplasty:

- Impairment of infant breastfeeding or suckling (including incompetent palatal seal and lip closure)
- Frenulum-related swallowing and/or masticatory difficulties
- Frenulum-related speech pathology
- A frenulum attachment coronal to the mucogingival junction that is resulting in damage to the periodontium, including gingival recession or stripping
- Provision of frenectomy or frenuloplasty will eliminate/reduce the need for orthodontic treatment or prevent a stable orthodontic outcome being compromised by adverse positioning of a frenulum attachment
- A frenulum attachment that is interfering with dental restorative treatment or the placement and/or function of a fixed or removable prosthetic appliance
- A frenulum attachment that is interfering with the ability to perform required oral hygiene, especially for individuals with complicating developmental or physical conditions that limiting their ability to maintain adequate oral health

For patients who do not meet the published qualifying criteria for frenectomy or frenuloplasty, Delta Dental will consider documentation from relevant clinicians that explains the necessity of covering frenectomy or frenuloplasty treatment for conditions not included in the criteria.

Depending on the clinical circumstances, the performance of frenectomy or frenuloplasty under the following conditions may be considered not medically necessary, inadvisable or deficient in clinical quality and may result in disapproval of benefits based on a professional determination that treatment is not medically necessary or not clinically appropriate:

- When the frenectomy or frenuloplasty is provided primarily for cosmetic reasons
- When frenectomy or frenuloplasty may compromise vital adjacent structures, including nearby neurovascular bundles (e.g., lingual or mental nerves)
- When the frenectomy or frenuloplasty is provided to address normal interdental spacing in the primary dentition

[1] Government regulations or the provisions of a member's dental plan that define when a dental procedure may be considered medically necessary and clinically appropriate with respect to benefit coverage may take precedence over these clinical criteria.

- When the patient presents with an acute or chronic comorbid disease state or local infection where frenectomy or frenuloplasty may result in a greater risk to health than the perceived benefit

Depending on an individual patient's condition and circumstances, the following additional criteria for frenectomy or frenuloplasty treatment may be applied for coverage determinations:

- When a frenulum is prone to frequent pain and injury as the result of normal daily dental care activities (e.g., brushing-induced abrasions and lacerations)
- When a qualified mental health provider has diagnosed an individual with a psychological disorder resulting from pronounced cosmetic compromise (e.g., a large anterior diastema) caused by a frenulum attachment
- When dental benefit programs have established program-specific criteria that define when frenectomy or frenuloplasty treatment is considered medically necessary and eligible for benefit coverage or that place other limitations on frenectomy or frenuloplasty coverage, Delta Dental will apply that criteria when there is a need to evaluate frenectomy or frenuloplasty treatment for medical necessity

Other Considerations

When the payment of benefits for a dental procedure by a member's dental plan depends on the application of clinical criteria to determine whether the procedure is medically necessary or clinically appropriate, the following additional information will be taken into consideration, if applicable:

- Individual patient characteristics including age, comorbidities, complications, progress of treatment, psychosocial situation and home environment
- Available services in the local dental delivery system and their ability to meet the member's specific dental care needs when clinical criteria are applied

Required Documentation

The decision to perform frenectomy or frenuloplasty on a patient should be based on a thorough clinical and radiographic examination that facilitates the formulation of an appropriate treatment plan. When the payment of benefits for frenectomy or frenuloplasty by a member's dental plan depends on a review of the procedure's medical necessity and clinical appropriateness, the treating practitioner should submit with the claim the following information as applicable from the patient's dental record. If the practitioner is unable to provide this information, benefit payment may be disapproved.

- Documentation consistent with the patient record that explains the diagnostic rationale for providing frenectomy or frenuloplasty for a patient, including the documented condition and/or diagnosis requiring treatment and any supporting information from the patient's dental and medical histories
- Patient treatment records from referring/involved dental, medical or mental health professionals, if applicable (e.g., documenting relevant diagnoses)
- Recent diagnostic radiographs of the involved dento-alveolar complex, if applicable (e.g., showing resultant bone loss)
- If applicable, preoperative six-point periodontal pocket depth charting performed within 12 months of treatment that includes documentation of clinical attachment loss, tooth mobility, bleeding on probing and furcation involvement

When determining coverage based on medical necessity or clinical appropriateness, Delta Dental may request other clinical information relevant to a patient's care if needed to make coverage decisions.

Additional Information

The provision of dental advice and clinical treatment of patients is the sole responsibility of treating dentists, and these clinical criteria are not intended to restrict dentists from carrying out that responsibility or recommend treatment to their patients.

Delta Dental's clinical criteria are developed and annually updated by a panel of licensed dental general practitioners and specialists serving on Delta Dental's Utilization Management (UM) Committee, including the Dental Director and Utilization Management Director. The criteria are developed in alignment with evidence-based clinical recommendations, guidelines and parameters of care of leading nationally recognized dental public health organizations, health research agencies and professional organizations, credible scientific evidence published in peer-reviewed medical and dental literature, the curriculum of accredited dental schools, the regulatory status of relevant dental technologies, the rules and requirements of the Centers for Medicare and Medicaid Services, Delta Dental national processing policies and input from practicing dentists. New and revised clinical criteria must be approved by the Dental Director and adopted by the UM Committee prior to release.

Federal or state statutes or regulations, dental plan contract provisions, local or national claim processing policies or other mandated requirements may take precedence over these clinical criteria.

Delta Dental reserves the right to modify or replace this document at any time as appropriate to ensure the soundness, accuracy and objectivity of Delta Dental's clinical criteria.

References

American Academy of Pediatric Dentistry. Policy on management of the frenulum in pediatric patients. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2024:73-8.

American Association of Oral and Maxillofacial Surgeons. Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2023). J Oral Maxillofac Surg. 2023 Nov;81(11):E51-E74.

American Dental Association, CDT 2025: Current Dental Terminology. American Dental Association, Chicago, IL, 2024.

Carnino JM, et al. The effect of frenectomy for tongue-tie, lip-tie, or cheek-tie on breastfeeding outcomes: A systematic review of articles over time and suggestions for management. Int J Pediatr Otorhinolaryngol. 2023 Aug:171:111638.

Devishree G, Shubhashini PV. Frenectomy: a review with the reports of surgical techniques. J Clin Diagn Res. 2012 Nov;6(9):1587-92.

Hupp JR, Tucker MR, Ellis E. Contemporary Oral and Maxillofacial Surgery. 7th ed. Elsevier; 2018.

Messner AH, et al. Clinical Consensus Statement: Ankyloglossia in Children. Otolaryngol Head Neck Surg 2020 May;162(5):597-611.

O'Shea JE, et al. Frenotomy for tongue-tie in newborn infants. Cochrane Database Syst Rev. 2017 Mar 11;3(3):CD011065.

Tadros S, et al. Association between superior labial frenum and maxillary midline diastema - a systematic review. Int J Pediatr Otorhinolaryngol. 2022 May:156:111063.

Walsh J, Benoit MM. Ankyloglossia and Other Oral Ties. Otolaryngol Clin North Am. 2019 Oct;52(5):795-811.