Surgical Extraction of Impacted Teeth (For Ohio Only)

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Related References and Policies

- UnitedHealthcare Community Plan of Ohio Medicaid Dental Quick Reference Guide
- Dental Provider Manual: UnitedHealthcare Community Plan of Ohio

Application

This Dental Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01. Early and periodic screening, diagnostic, and treatment (EPSDT) covered dental service considerations are applied to members younger than age 21 years of age pursuant to Ohio Administrative Code 5160-1-14(C)(3).

Prior Authorization

The Ohio Department of Medicaid (ODM) determines coverage of dental services based on medical necessity, alignment with policy criteria, and clinical indications. CDT codes that are designated as covered by ODM are eligible for reimbursement when all applicable guidelines are met. For a comprehensive list of covered CDT codes, refer to the UnitedHealthcare Community Plan of Ohio Medicaid Dental Quick Reference Guide and/or Dental Provider Manual: UnitedHealthcare Community Plan of Ohio.

Non-covered codes may be reimbursable if special justification is submitted to include prior-authorization, clinical narrative of medical necessity, and supporting documentation including but not limited to clinical records, diagnostic imaging, periodontal charting, or any other relevant documentation to support the clinical rationale.

Description of Services

Surgical extraction of impacted teeth is required when the tooth has not erupted in the oral cavity and is covered by soft tissue and/or bone, and the procedure requires the cutting of these tissues. The most commonly affected teeth are third molars and maxillary canines, but impaction can occur with any teeth.

Nerve dissection is the separation or isolation of a nerve from surrounding tissues, and is typically inclusive to the primary extraction procedure. A separate nerve dissection procedure may be required to avoid iatrogenic injuries to craniofacial

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nerves, and this is influenced by the type of procedure and location (e.g., parotid gland, neck dissection, fracture management, or implant placement) and individual patient anatomy (Renton 2013).

Definitions

Completely Bony Impaction: Most or all of a tooth crown is covered by bone; requires mucoperiosteal flap, elevation and bone removal. (ADA)

Completely Bony Impaction with Unusual Surgical Complications: Most or all of a crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, or aberrant tooth position. (ADA)

Coronectomy: Intentional partial tooth removal performed when a neurovascular complication is likely if the entire Impacted Tooth is removed. (ADA)

Impacted Tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely. (ADA)

Partially Bony Impaction: Part of tooth crown covered by bone; requires mucoperiosteal flap elevation and bone removal. (ADA)

Soft Tissue Impaction: Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. (ADA)

Clinical Indications

Covered Codes

CDT Code	Age Limits	Frequency Limits	Authorization Required	Required Documentation
D7220	0-999	1 per 1 lifetime per member	No	Tooth #1, #16, #17, and #32 do not require prior authorization for this code.
D7220	0-999	1 per 1 lifetime per member	Yes	Teeth 2-15, 18-31; Current pre-op panoramic x-ray; Narrative of medical necessity
D7230	0-999	1 per 1 lifetime per member	No	N/A
D7240	0-999	1 per 1 lifetime per member	Yes	Current pre-op panoramic x-ray; Narrative of medical necessity
D7241	0-999	1 per 1 lifetime per member	Yes	Current pre-op panoramic x-ray; Narrative of medical necessity

Surgical Extraction of Soft Tissue, Partially Bony and Complete Bony Impacted Teeth

Surgical extraction of Soft Tissue, Partially Bony and Complete Bony Impacted Teeth is indicated for the following:

- The facilitation of orthodontic treatment
- For a tooth/teeth in the line of a jaw fracture or complicating fracture management
- As part of comprehensive treatment in orthognathic surgery
- Moderate to severe or acute pain, or recurrent episodes that do not respond to conservative treatment (i.e., pain medication or antibiotics)
- Non restorable caries
- Management of, or limiting the progression of periodontal disease
- In the case of acute/chronic infection (abscess, cellulitis, pericoronitis)
- Pulpal exposure
- Non restorable pulpal or periapical lesion
- Internal/External resorption

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- As a prophylactic procedure for an underlying medical or surgical condition (e.g., organ transplants, alloplastic implants, chemotherapy, radiation therapy prior to intravenous bisphosphonate therapy)
- Tumor resection
- Ectopic position
- For purposes of prosthetic rehabilitation (partial dentures and complete dentures)
- When the third molar is causing or at risk of causing pathology to the adjacent second molar

Surgical extraction of Soft Tissue, Partially Bony and Complete Bony Impacted Teeth is not indicated for the following:
- For prophylactic reasons other than an underlying medical condition
- For pain or discomfort related to normal tooth eruption

Coronectomy

Coronectomy is indicated for the following:
- When clinical criteria for extraction of impacted teeth is met; and
- If the removal of the complete tooth would result in damage to the neurovascular bundle

Coronectomy is not indicated for teeth with the following conditions:
- Mobility
- Root surface decay
- Periapical pathology
- Horizontal impactions in direct contact with nerves

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 policy 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 Policies and Guidelines may apply.

CDT Code	Description
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – complete bony
D7241	Removal of impacted tooth – complete bony, with unusual surgical complications
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only
D7259	Nerve dissection

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Clinical Evidence

Yang et al., (2023) conducted a cross sectional analysis to assess the occurrence of distal pathologies of adjacent second molars in the presence of asymptomatic third molars. Included were 248 patients and 805 quadrants that were examined clinically and radiographically. The results showed that irrespective of impaction status, the presence of asymptomatic third molars increased the odds of the presence of caries and periodontal disease even after controlling for confounding factors such as age and overall periodontal status. Non impacted third molars in the mandible were more than twice as likely to contribute to periodontal probing depths greater than 4 mm on the distal of the adjacent second molar than the maxillary. The authors concluded that this study provides evidence for more proactive intervention regarding asymptomatic third molars and prophylactic removal to decrease the risk of second molar pathologies.

In a 2020 updated Cochrane Database systematic review, Ghaemina et al. evaluated the effects of removal versus retention of asymptomatic, disease free third molars in adolescents and adults. This updated includes the same two studies reviewed in 2016, one RCT and one prospective cohort study. No studies reported the effects of removal vs

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retention on health related QOL. Very low certainty evidence suggests that the presence of asymptomatic disease-free impacted wisdom teeth may be associated with increased risk of periodontitis affecting the adjacent second molar in the long term. There is insufficient evidence to show difference in caries risk, or if removal or retention has a significant impact on dimensional changes of the dental arch in patients that previously underwent orthodontic treatment. Neither study reported on other outcomes including adverse effects of retaining third molars such as infection, root resorption or cyst or tumor formation. The authors concluded that there is insufficient evidence to determine if asymptomatic, disease free third molars should be removed or retained, and decisions should be made on an individual patient basis using shared decision making principles. Furthermore, if asymptomatic third molars are retained, clinical assessment at regular intervals is advised (Ghaemina et al., 2016 was previously cited in this policy).

Toedtling et al. (2019) conducted a systematic review and meta-analysis of epidemiological studies to assess the prevalence of distal surface caries (DSC) in second molars that are adjacent to impacted third molars. The meta-analysis included 3 studies and showed that the prevalence of DSC among third molars that were inclined mesially and horizontally were significantly higher than those that were inclined distally or vertically. The meta-analysis showed that about 1 in 4 are affected by DSC, with most significant associations being between mesially and horizontally impacted third molars.

Smailienė et al. (2019) conducted a retrospective study using cone beam computerized tomography (CBCT) to assess the relationship between external root resorption (ERR) on the distal aspect of second molars' roots and positional parameters of impacted third molars (ITM). Cone beam computed tomography scans of 109 patients (41 males, 68 females; mean age 26.4 ±7.9 years) with 254 ITM (131 in the maxilla and 123 in the mandible) were retrospectively analyzed. Positional parameters of ITM (mesio-distal position, angulation, impaction depth, and available eruption space) were evaluated. The presence, location, and depth of ERR of adjacent second molars were assessed. Analysis showed a relationship between ITM impaction depth, mesial inclination angle, and the presence of ERR. Mesial inclination angle of more than 13.6° increased the odds of ERR occurrence by 5.439 (95% CI, 2.97-9.98). ITM presence at the level of ½ of roots of the adjacent second molar or more apically increased the odds of ERR occurrence by 2.218 (95% CI, 1.215-4.048). No significant correlation was detected between the occurrence of ERR and patient age, gender, or the available eruption space in the mandible. Depth of ERR did not depend on its location. The author’s concluded that the incidence of ERR in second molars is significantly associated with mesial inclination and a deep position of ITM.

Monaco et al. (2019) conducted a prospective cohort study of early (up to 1 month) and late (from 2 to 60 months) postoperative complications following coronectomy to reduce the risk of neurologic damage to the inferior alveolar nerve (IAN). 116 coronectomies in 94 healthy patients (37 men and 57 women; mean age, 28.99 ±8.9 years) were completed, and at 5 years' follow-up, re-evaluated 63 patients with 76 coronectomies. In total, 30 complications were verified. No cases of neurologic lesions to the IAN or lingual nerve were observed after surgery. In the first 3 years, the surgeons extracted migrated roots in 5 cases (6%) without any neurologic lesions to the IAN. No complications were observed from the third to fifth year. The author’s concluded no cases of neurologic lesions, no cases of late infection of the retained roots at 5 years, and a low rate of immediate postoperative complications. Further investigations should include a follow-up study at 10 years and more research about the mechanism of pulp healing.

Mukherjee et al (2016) Iatrogenic damage to Inferior Alveolar Nerve (IAN) is a significant risk factor following prophylactic or therapeutic removal of impacted mandibular third molar. The risk to IAN injury increases many fold, when the third molar root overlaps the nerve canal as identified by the radiographic imaging. The aim of this study was to evaluate the fate of the root (resorbed, exfoliated, and covered by bone) after coronectomy or intentional root retention of impacted mandibular 3(rd) molars in patients with high risk for inferior alveolar nerve damage as evaluated by the intra oral periapical radiograph. Twenty impacted mandibular third molar teeth, in 18 patients with high risk of injury to IAN based on Rood's Criteria in an intra-oral periapical radiographic examination, between the age group of 18 to 40 years, were included in the study. Preoperatively the impacted third molars were evaluated clinically as well as radiographically. Pederson Difficulty Index and Winter's Classification of impacted tooth was recorded. Coronectomy was done at the cemento enamel junction leaving the roots 2-3mm below the alveolar crest and primary closure was done. Patients were evaluated periodically for two years at six months interval. Post-operative pain, swelling, IAN injury or any other complications were observed and recorded. The results showed none of the patients had IAN injury, required a second surgery to remove roots, or developed a post-operative infection. However, two patients had failed coronectomy (10%) due to mobilization of roots intra operatively and the roots were removed. One patient developed profuse bleeding intra-operatively in the failed coronectomy case. One patient had temporary lingual nerve paresthesia. The authors concluded that a coronectomy procedure is effective in controlling inferior alveolar nerve injury following third molar surgery, in radiographically evaluated high risk cases and it has very low incidence of complications.

Long et al. (2015) conducted a systemic review, to compare the outcomes between coronectomy and total removal for third molar extractions with high risk of nerve injury. PubMed, Embase, Web of Science, CENTRAL, and SIGLE database

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searches were conducted from January 1990 to October 2011, and included review of randomized or non-randomized controlled trials. Four studies met the inclusion criteria. A relatively high rate of failed coronectomy in one study (38.3%, compared with 2.3%-9.4% in others) may be attributed to a higher proportion of narrowing roots and vertical impactions. Although root migration rate was high (13.2%-85.29%), the migration distances were short (3.06 ±1.67 mm), and the directions were away from the nerves. Moreover, the rates of re-operation and root exposure were low. It was concluded that coronectomy is superior to total removal for reducing inferior alveolar nerve damage and could be used in clinical practice for third molar extractions with high risk of nerve injury.

Martin et al. (2015) conducted in systematic review that examined the clinical outcomes after coronectomy. PubMed, SCOPUS and the Cochrane Library publications were reviewed through January 31, 2014 and this included randomized clinical trials, controlled clinical trials, prospective cohort studies or retrospective studies. Ten articles qualified for the final analysis. The successful coronectomy varied from a minimum of 61.7% to a maximum of 100%. Several variables were evaluated, including inferior alveolar nerve (IAN) injury, lingual nerve (LN) injury, and postoperative adverse effects, pulp disease, and root migration. Coronectomy was associated with a low incidence of complications in terms of the variables evaluated, with the exception of migration of the retained roots which ranged from 2%-85.3%. It was concluded that coronectomy appears to be a safe procedure, with a reduced incidence of postoperative complications, and a coronectomy can be indicated for teeth that are very close to the inferior alveolar nerve. If a second operation is needed for the remnant roots, they can be removed with a low risk of paresthesia, because the roots have likely migrated away from the mandibular nerve.

Agbaje, JO et al.(2015) conducted a study to assess the surgical management of impacted third molar with proximity to the inferior alveolar nerve and complications associated with coronectomy in a series of patients undergoing third molar surgery. The position of the mandibular canal in relation to the mandibular third molar region (and mandibular foramen in the front part of the mandible) was identified on panoramic radiographs of patients scheduled for third molar extraction. Close proximity to the inferior alveolar nerve (IAN) was observed in 64 patients with an impacted mandibular third molar. Coronectomy was performed in these patients. Coronectomy did not increase the incidence of damage to the inferior alveolar nerve and would be safer than complete extraction in situations in which the root of the mandibular third molar overlaps or is in close proximity to the mandibular canal. The most common complication was tooth migration away from the mandibular canal (n = 14), followed by root exposure (n = 5). The results of this study indicate that coronectomy can be considered a reasonable and safe treatment alternative for patients who demonstrate elevated risk for injury to the inferior alveolar nerve with removal of the third molars.

Stathopoulos et al. (2011) conducted a retrospective analysis over an 11 year period from 1990-2001 assessing the type and frequency of cysts and tumors associated with impacted third molars (ITM). 7,782 ITMs were identified in 6,182 patients with the main reason for surgical removal being signs and symptoms of infection due to pericoronitis. The ages of the patients ranged from 12 to 92 years, with a mean of 32.7 years. The ratio of maxillary to mandibular molars was 1:2.9. Of the 7,782 ITM specimens examined, 417 met inclusion criteria with a pericoronal space of greater than 3 mm on the panoramic radiograph and were submitted for histopathologic examination. Of the 417 specimens submitted for examination, 167 cysts (40.04%) of which the majority were dentigerous or odontogenic keratocysts, 48 benign tumors (11.5%) that included ameloblastoma, odontoma, odontogenic myxoma, odontogenic fibroma, as well as 202 normal dental follicles (48.44%) were found. This retrospective analysis concluded that the incidence of cyst and tumor development around ITMs is low (2.77%) and suggests that, as far as the prevention of cyst and tumor development around ITMs is concerned, surgical removal is not sufficiently justified.

Professional Societies

American Association of Oral and Maxillofacial Surgeons (AAOMS)

In the 2016 white paper on the management of third molar teeth, AAOMS states the following:
“In the absence of evidence regarding current associated symptoms or disease to support surgical management, the surgeon should review the likelihood of pathology developing in the future, functionality, risks of removal, risks of retention, and protocol for active surveillance. Removal should be favored when the third molar is currently or likely to be non-functional, there is an overlying removable prosthesis, orthodontic removal is justified (such as when the tooth is preventing the eruption of the second molar) and in the case of planned orthognathic surgery. Patients should also be informed of the greater difficulty and increased rate of complications associated with third molar removal as they age. When appropriate, patients should be advised that if they retain their disease-free wisdom teeth, it is possible they could live their entire lives without problems”.

In a 2017 clinical paper, updated in 2024, on the management of impacted third molars, AAOMS states that all impacted third molar teeth are potentially pathologic and prudent care requires removal, exposure, repositioning, or long term monitoring in selected cases.

- Indications for treatment include, but are not limited to:

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- Pain
- To facilitate the management or limit progression of periodontal disease
- Ectopic position
- To facilitate prosthetic rehabilitation
- To facilitate orthodontic tooth movement and promote dental stability
- Tooth interfering with orthognathic and/or reconstructive surgery
- Fractured tooth
- Nonrestorable caries
- Internal or external resorption of tooth or adjacent teeth
- Tooth involved in tumor resection
- Prophylactic removal in patients with certain medical or surgical conditions or treatments (e.g., organ transplants, alloplastic implants, chemotherapy, radiation therapy)
- Patient's informed refusal of nonsurgical treatment options
- Nontreatable pulpal lesion
- Acute or chronic infection (e.g., cellulitis, abscess)
- Abnormalities of tooth size or shape
- The presence of periodontal disease
- The presence of periapical pathology
- Elective therapeutic removal
- Tooth in the line of a jaw fracture complicating fracture management
- Pathology associated with tooth follicle (e.g., cysts, tumors)
- Facilitate management in trauma, orthognathic or reconstructive surgery
- Insufficient space to accommodate erupting tooth or teeth
- Orthodontic abnormalities (e.g., arch length/ tooth size discrepancies)

AAOMS makes the following additional statements:

- Consideration may be given to maintaining an impacted third molar tooth in place when it has complete root formation, is totally covered by bone, and does not meet any of the clinical and/or radiographic indications for removal listed above. In these cases, long-term clinical and radiographic observation is necessary, and the patient must be informed of the risks and benefits of surgical intervention versus maintenance of the tooth and long-term observation.
- Contraindications to the removal of impacted teeth include the medically compromised, extremes of age and the probability of damage to adjacent structures.
- When the impacted tooth is in a position close to or impinging upon vital structures such as the inferior alveolar nerve and there are clinical indications for removal of the tooth, a coronectomy may be appropriate.

National Comprehensive Cancer Network (NCCN)

In the NCCN guidelines on head and neck cancers, Principles of Oral/Dental Evaluation and Management section, states that there is a need for a pre-radiation treatment evaluation to determine the need for any dental extractions. This should take into consideration the long-term prognosis of the teeth as well as patient motivation. Necessary extractions should occur at least 2 weeks prior to the start of radiation. Furthermore, the oncology team should be consulted for any future extractions or procedures in the irradiated field.

In the guidelines for hematopoietic cell transplant, the NNCN states that for allogeneic transplants, a dental evaluation should be done as clinically indicated.

American Academy of Pediatric Dentistry (AAPD)

In a 2022 best practice guideline on the dental management of pediatric patients receiving immunosuppressive therapy and/or head and neck radiation, the AAPD states that all children undergoing these procedures should have a comprehensive oral and dental examination before treatment. With regard to extractions, the guideline states that while some practitioners prefer to extract all third molars that are not fully erupted, others have a more conservative approach and only recommend extraction of third molars at risk for pulpal infection, with significant pathology, infection, periodontal disease, or when malposed or nonfunctional, extractions should be as atraumatic as possible, leaving no sharp bony edges and proper would closure. Extractions should be ideally performed three weeks (at least 10-14 days) prior to treatment to allow healing.

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Policy History/Revision Information

Date	Summary of Changes

12/01/2026	**Template Updates**
	• Renamed *Related Dental Policy* to *Related References and Policies*
	• Reordered contents of policy
	  ○ Moved *Description of Services* and *Definitions* towards beginning of policy
	• Added *Prior Authorization* section
	• Renamed *Coverage Rationale* to *Clinical Indications*
	  ○ Added Covered Codes
	Supporting Information
	• Updated *Description of Services, Clinical Evidence* and *References* sections to reflect the most current information
	• Removed *FDA* section
	• Archived previous policy version CSDEN434OH.A

Instructions for Use

This Dental Policy provides assistance in interpreting the UnitedHealthcare Community Plan of Ohio dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plans may differ. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Dental Policy is provided for informational purposes. It does not constitute the practice of medicine or medical advice.

Archived Policy Versions

Effective Date	Guideline Number	Guideline Title
11/01/2025 – 11/30/2026	CSDEN434OH.A	Surgical Extraction of Impacted Teeth
12/01/2023 – 10/31/2025	CSDEN339OH.A	Surgical Extraction of Impacted Teeth

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