Oral Surgery: Non-Pathologic Excisional Procedures (For Ohio Only)

Policy Number: CSDEN437OH.B
Effective Date: December 1, 2026

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Related References andPolicies

- 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

Oral surgery excisional procedures involve the removal and/or alteration of hard and soft oral tissues to achieve normal physiologic function or allow the proper fit of removable appliances.

Definitions

Ankyloglossia: Partial or complete fusion of the tongue with the floor of the mouth or the lingual gingiva due to an abnormally short, mid-line lingual Frenulum, resulting in restricted tongue movement (also known as tongue-tie). (AAP)

Exostosis/Exostoses: A benign, bony growth projecting outward from the surface of a bone. (AAP)

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Frenum/Frenulum: A fold of mucous membrane tissue that attaches the lips and cheeks to the alveolar mucosa (and/or gingiva) and underlying periosteum (AAP).

The Placek's Classification of Labial Frenal Attachments (Devishree et. al):
- Mucosal: When the frenal fibres are attached up to the mucogingival junction
- Gingival: When the fibres are inserted within the attached gingiva
- Papillary: When the fibres are extending into the interdental papilla
- Papilla Penetrating: When the frenal fibres cross the alveolar process and extend up to the palatine papilla

Hyperplastic: The increase in the size of a structure due to an increase in the number of cells. (AAP)

Torus Mandibularis: A bony exostosis on the lingual aspect of the mandible, generally in the premolarmolar region; commonly bilateral. (AAP)

Torus Palatinus: A bony protuberance occurring at the midline of the hard palate. (AAP)

Tuberosity: An osseous projection or protuberance. (AAP)

Clinical Indications

Covered Codes

CDT Code	Age Limits	Frequency Limits	Authorization Required	Required Documentation
D7471	0-999	1 per lifetime per arch	No	N/A
D7472	0-999	1 per lifetime	No	N/A
D7473	0-999	1 per lifetime	No	N/A
D7961	0-18 months	1 per lifetime	Yes	Narrative of medical necessity accompanied by corroborating physician note
D7961	19 months - 999	1 per lifetime	No	N/A
D7962	0-18 months	1 per lifetime	Yes	Narrative of medical necessity accompanied by corroborating physician note
D7962	19 months - 999	1 per lifetime	No	N/A
D7970	0-999	1 per lifetime per arch	No	N/A

Frenulectomy/Frenuloplasty

Frenulectomy and Frenuloplasty are indicated for the following:
- When attachment of the Frenum is coronal to the mucogingival junction, within the free gingiva, or in the papilla causing a diastema, gingival recession, or stripping
- When the position attachment of the Frenum is interfering with proper oral hygiene
- Prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech
- For Ankyloglossia or papillary penetrating attachment of maxillary labial Frenum in newborns when there is interference with feeding

Excision of Hyperplastic Tissue and Surgical Reduction of Fibrous Tuberosity

Excision of Hyperplastic tissue and surgical reduction of a fibrous tuberosity is indicated when the presence of excess tissue interferes with the fit of a partial or complete denture (existing or new).

Excision of Pericoronal Gingiva

Excision of pericoronal gingiva is indicated for the following:

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- For recurrent infections of the operculum around impacted or partially erupted lower third molars
- When an erupted maxillary third molar is traumatizing soft tissue around opposing tooth
- When the presence interferes with the fit of a partial or complete denture

Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report

Transseptal fiberotomy/supra crestal fiberotomy is indicated to reduce rotational relapse of individual teeth following orthodontic treatment.

Excisional procedures may not be indicated for the following:
- Individuals with an unmanaged medical condition; these conditions include but are not limited to metabolic, cardiovascular, and autoimmune/inflammatory, as well as genetic conditions that affect collagen synthesis
- Individuals taking medications that negatively affects the healing response; these include but are not limited to immunosuppressive agents, corticosteroids, anticoagulants, NSAIDS, and nicotine

Removal of Lateral Exostosis (Maxilla or Mandible), Torus Palatinus and Torus Mandibularis

Removal of lateral Exostoses, Torus Palatinus, and Torus Mandibularis is indicated for the following:
- If a partial or complete denture cannot be adapted successfully
- When causing soft tissue trauma with existing removable appliances
- For unusually large protuberances that are prone to recurrent traumatic injury
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech

Removal of lateral Exostoses**,** Torus Palatinus**, and** Torus Mandibularis **may not be indicated for the following:**
- Individuals with an unmanaged medical condition; these conditions include, but are not limited to, metabolic, cardiovascular, and autoimmune/inflammatory, as well as genetic conditions that affect collagen synthesis
- Individuals taking medications that negatively affects the healing response; these include, but are not limited to, immunosuppressive agents, corticosteroids, anticoagulants, NSAIDS, and nicotine
- For individuals who have undergone radiation therapy to the head and neck

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 guideline 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
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7961	Buccal / labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue – per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity
D7999	Unspecified oral surgery procedure, by report

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References

Akylacin S, Kapadia H, English J. Mosby's Orthodontic Review, 2nd ed. St. Louis: Mosby c2015. Chapter 23, Retention and Relapse in Orthodontics; p. 297.

American Academy of Pediatric Dentistry Guideline on Management Considerations for Pediatric Oral Surgery and Oral Pathology. Adopted 2005. Revised 2025.

American Academy of Peridontology (AAP) Glossary of Periodontal Terms.

American Dental Association (ADA) CDT Codebook 2025.

American Dental Association Glossary of Clinical and Administrative Terms.

Carr A, Brown D. McCracken's Removable Partial Prosthodontics, 13th ed. St. Louis: Mosby c2016. Chapter 14, Preparation of the Mouth for Removable Partial Dentures; p. 190-191.

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

Kerr A, Miller C, Nelson R. Little and Falace's Dental Management of the Medically Compromised Patient, 10th ed. St. Louis: Elsevier c2024. Chapter 1, Patient Evaluation, Risk Assessment, and the Diagnostic Process; p. 1-17.

Ness G. Atlas of Oral and Maxillofacial Surgery, 2nd ed. St. Louis: Elsevier c2023. Chapter 15, Palatal and Lingual Torus Removal.

Takei E. Scheyer T, Azzi R, et al. Newman and Carranza's Clinical Periodontology, 13th ed. St. Louis: Mosby c2019. Chapter 65, Periodontal Plastic and Esthetic Surgery; p. 660-663.

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* **Coverage Rationale** ***Removal of Lateral Exostosis (Maxilla or Mandible), Torus Palatinus, and Torus Mandibularis*** • Added language stating: ○ Removal of lateral Exostoses, Torus Palatinus, and Torus Mandibularis may not be indicated for the following: ▪ Individuals with an unmanaged medical condition; these conditions include but are not limited to metabolic, cardiovascular, and autoimmune/inflammatory, as well as genetic conditions that affect collagen synthesis ▪ Individuals taking medications that negatively affects the healing response; these include but are not limited to immunosuppressive agents, corticosteroids, anticoagulants, NSAIDS, and nicotine ▪ For individuals who have undergone radiation therapy to the head and neck **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version CSDEN437OH.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.

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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	CSDEN437OH.A	Oral Surgery: Non-Pathologic Excisional Procedures
12/01/2023 – 10/31/2025	CSDEN327OH.A	Oral Surgery: Non-Pathologic Excisional Procedures

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