Driscoll Health Plan
Medical Necessity Guideline

Medical Necessity Guideline: Lingual Frenectomy (frenotomy, frenumectomy, frenulectomy)	**Creation Date:** 11/19/2018	**Review Date:** 05/30/2025	**Effective Date:** 07/17/2025

PURPOSE:

To detail the indications and authorization requirements for Lingual Frenectomy (frenotomy, frenulectomy) - except, in the first month of life, the inability to effectively breast or bottle feed as a result of the condition.

LINE OF BUSINESS: STAR, STAR Kids, and CHIP

DEFINITIONS:

Ankyloglossia - often called "tongue-tie" is a common congenital anomaly usually detected soon after birth. It is characterized by partial fusion, or in rare cases total fusion of the tongue to the floor of the mouth due to an abnormality of the lingual frenulum [(1)].

Frenectomy - (also called frenotomy, frenumectomy, frenulectomy) is a simple release, or "clipping," of the frenulum.

GUIDELINE:

Driscoll Health Plan (DHP) requires prior authorization of all requests for lingual frenulectomy - with the exception of infants in the first month of life who experience a failure to gain weight.

Frenulectomy or frenotomy of the lingual frenulum for ankyloglossia is considered medically necessary and, therefore, covered for any of the following symptoms:

1. Difficulty with breastfeeding or bottle-feeding
2. Difficulty chewing (mastication)
3. Unusual swallowing
4. Limitation of the tongue to reach the palatal retro-incisal spot when the mouth is open
5. Invagination of the tongue tip
6. Speech impediment:
    a. In evaluating the effect of ankyloglossia on speech, it is important to focus on lingual-alveolar sounds (particularly /l/) and interdental sounds (voiced and voiceless /th/).
    b. Tongue-tie could be considered a contributing factor if the child cannot produce these sounds, and all other speech sounds are produced normally.
    c. Tongue tie may also be a bigger problem if there is oral-motor dysfunction [(1)].

4525 Ayers St.
Corpus Christi, Texas 78415
Telephone (877) 455-1053 Fax (866) 741-5650

d. A consultation with a speech pathologist is encouraged before frenotomy/frenuloplasty in an older child who is undergoing the procedure for speech concerns." [2]

Required Documentation:

Requests for lingual frenectomy (frenotomy, frenumectomy, frenulectomy) should include a history and physical describing any limitation of tongue movement, difficulty swallowing/feeding, and a growth chart suggestive of failure to thrive due to that difficulty. Formal speech evaluation may be required if there is a question of speech difficulties.

BACKGROUND:

ANATOMY

The lingual frenulum is frequently referred to as a "cord" or "submucosal band" of connective tissue. The lingual frenulum is a dynamic structure formed by a midline fold in a layer of fascia that inserts around the inner arc of the mandible, forming a diaphragm-like structure across the floor of the mouth. This fascia is located immediately beneath the oral mucosa, fusing centrally with the connective tissue on the tongue's ventral surface. The fascial layer envelops the sublingual glands, and the submandibular ducts and the anterior genioglossus fibers are suspended beneath [3]. Thus, the configuration and contents of the lingual frenulum vary depending on the force applied to the tongue. There is considerable individual variation in the appearance of the lingual frenulum under tension. It may insert on the tip of the mobile tongue or along its undersurface. In some normal infants, no frenulum is seen connecting the floor of the mouth and mobile tongue [4].

EPIDEMIOLOGY

The reported prevalence of ankyloglossia varies from <1 percent to 10 percent, depending upon the study population and criteria used to define ankyloglossia. A uniform definition and objective grading system for tongue-tie are lacking, though standardized measurement techniques and norms have been proposed. In most series, the frequency of tongue-tie is higher among boys, with a male to female ratio of 1.5:1 to 2.6:1 [4].

FUNCTIONAL EFFECTS

For patients with ankyloglossia, the functional effects can include the following:

- Feeding problems:
  The literature on ankyloglossia primarily deals with potential breastfeeding difficulties [1, 2, 4, 5, 6]. Although approximately 25% of newborns with ankyloglossia will have some trouble latching on to a nipple for sucking, most have no early feeding problems. "While

the group was able to come to a consensus that frenotomy in infants with ankyloglossia can improve breastfeeding, not all infants with ankyloglossia need to have a frenotomy, and there are other more common causes of breastfeeding difficulties." [2] As the child grows older, he may have difficulty moving a bolus in the oral cavity and clearing food from the sulci and molars. This problem could result in chronic halitosis and contribute to dental decay.

- Dentition: If the lingual frenulum is attached high on the gingival ridge behind the lower mandibular incisors, it can pull the gingiva away from the teeth and cause a mandibular diastema. However, this is usually not a problem until age 8 to 10.
- Cosmetics and personal interactions: There is no doubt that ankyloglossia may look abnormal and has even been described as a forked or "serpent" tongue. There can also be difficulty in social and recreational functions like "French" kissing, licking an ice cream cone, or catching snowflakes on one's tongue.
- Speech: Through the centuries, it has been a common folk belief that if the tongue tip cannot move well due to ankyloglossia, it must affect speech. This is even mentioned in the Bible. In Mark 7:35, it says "… and the bond that tied his tongue was loosed, and he talked plainly." Despite the common belief of this effect, there is no empirical evidence in the literature that ankyloglossia typically causes speech defects. On the contrary, several authors, even from decades ago, have disputed the belief that there is a strong causal relationship [1, 5]. In addition, there are very few other articles in the literature that even address the effects of tongue-tie on speech [1].

There is virtually no evidence in the literature to establish a definite causal relationship between ankyloglossia and speech disorders. Furthermore, very little in the literature addresses ankyloglossia and speech. This is probably because a causal relationship is not what is typically seen clinically. Therefore, it can be assumed that ankyloglossia is unlikely to cause speech problems in most cases. [2]

SURGERY FOR ANKYLOGLOSSIA

Frenectomy is used interchangeably with frenotomy, frenumectomy, and frenulectomy. It is a simple release, or "clipping," of the frenulum. This procedure is often performed for infants with breastfeeding difficulty, with or without local anesthesia [4]. However, in older children, the operation requires general anesthesia to ensure adequate cooperation from the patient to gain access to the floor of the mouth to perform the procedure [1].

Frenectomies are usually done by either a general surgeon, otolaryngologist, plastic surgeon, or oral surgeon. Although these surgeries are commonly done, there is no consistency in what are considered indications for the surgery. In a survey of oral and maxillofacial surgeons, plastic surgeons, and general pediatric surgeons in Australia who perform frenotomies, Brinkman et al. [4, 8] reported that "There was no clear consensus regarding clinical indicators for surgery or functional outcomes following surgery." Finally, a Cochrane review of frenotomy published in

2017 concluded that there was a lack of quality scientific studies regarding frenotomy particularly as this relates to difficulties with breastfeeding. (9)

PROVIDER CLAIMS CODES:

CPT	
41010	Incision of lingual frenum (frenotomy)
41115	Excision of lingual frenum (frenectomy)
40806	Incision of labial frenum
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)

ICD-10	
Diagnosis codes	
Q38.1	Ankyloglossia
For feeding difficulties	
R63.3	Feeding difficulties
P92.5	Neonatal difficulty in feeding at breast
P92.8	Other feeding problems of newborn
P92.9	Feeding problem of newborn, unspecified
For childhood articulation problems	
F80.0	Phonological disorder
F80.89	Other developmental disorders of speech and language
F80.9	Developmental disorder of speech and language, unspecified

REFERENCES:

1. Kummer, A. W. (2005). Ankyloglossia: To Clip or Not to Clip? That's the Question. The ASHA Leader. Access: https://leader.pubs.asha.org/doi/10.1044/leader.FTR2.10172005.6

2. Messner, A. H., et al. (2020). Clinical Consensus Statement: Ankyloglossia in Children. Otolaryngol Head Neck Surg, 162(5), 597-611. Access:https://pubmed.ncbi.nlm.nih.gov/32283998/

3. Mills, N., et al. (2019). What is a tongue tie? Defining the anatomy of the in-situ lingual frenulum. Clinical Anatomy, 32(6), 749-761.

4. DynaMed. Neonatal Ankyloglossia. Ipswich, MA: EBSCO Information Services. Updated November 30, 2018. Access: https://www.dynamed.com/condition/neonatal-ankyloglossia-20#GUID-CC0E9D9F-CFF6-469E-A8CE-428825F25C36

5. Ricke, L. A., et al. (2005). Newborn tongue-tie: prevalence and effect on breastfeeding. J Am Board Fam Pract, 18(1), 1-7.

6. Fitz-Desorgher, R. (2003). All tied up. Tongue-tie and its implications for breastfeeding. Practicing Midwife, 6(1), 20–22.

7. Block, J. R. (1968). The role of the speech clinician in determining indications for frenulotomy in cases of ankyloglossia. NY State Dent J, 34(8), 479–481.

8. Brinkmann, S., et al. (2004). Management of tongue-tie in children: a survey of paediatric surgeons in Australia. J Paediatr Child Health, 40(11), 600–605..

9. O'Shea, J. E., et al. (2017). Frenotomy for tongue-tie in newborn infants. Cochrane Database Syst Rev, (3), CD011065.

DOCUMENT HISTORY:

DHP Committee that Approved	***Review Approval Date (last 5 years)***				
Medical Director	06/07/2022	05/23/2023	05/31/2024	05/13/2025	
CMO	06/07/2022	06/06/2023	06/11/2024	06/10/2025	
Medical Policy Workgroup	06/07/2022	06/06/2023	06/11/2024	06/10/2025	
Utilization Management & Appeals	06/21/2022	06/20/2023	06/18/2024	06/17/2025	
Provider Advisory Committee (PAC)	06/17/2022	06/09/2023	07/01/2024	06/24/2025	
Clinical Management Committee	06/24/2022 & 08/23/2022	07/20/2023	07/24/2024	07/01/2025	
Executive Quality Committee	06/28/2022	07/25/2023	07/30/2024	07/17/2025	

Document Owner	***Organization***	***Department***
Dr. Fred McCurdy, Medical Director	Driscoll Health Plan	Utilization Management

Review/Revision Date	*Review/Revision Information, etc.*
11/30/2019	Updated to new format by Dr. Tom Morris – original author Dr. Riaz Shareef – added additional references
05/21/2020	Extensive rewrite and additional references. Updated format – Dr. Akhtar and Morris
06/16/2020	Recommendations per Dr. Serrao – Dr. Akhtar and Dr. Brendel
05/22/2021	Added new reference, updated and validated current references and codes – Dr.Akthar
05/09/2022	Reviewed and updated by Dr. Thomas Morris
05/23/2022	Reviewed, edited, and new codes added by Dr. Fred McCurdy
05/23/2023	Reviewed by Drs Thomas Morris and Fred McCurdy
05/31/2024	Reviewed and revised by Drs. Tessa Perez and Fred McCurdy
05/13/2025-5/30/2025	Annual Review and revision initiated on 05/13/2025 and completed on 05/30/2025 by Dr. Tessa Perez

4525 Ayers St.
Corpus Christi, Texas 78415
Telephone (877) 455-1053 Fax (866) 741-5650