

Driscoll Health Plan Medical Necessity Guideline

| | | | |
|---|-------------------------------------|-----------------------------------|--------------------------------------|
| Medical Necessity Guideline: Lingular Frenectomy (frenotomy, frenumectomy, frenulectomy) | Creation Date: 11/19/2018 | Review Date: 05/31/2024 | Effective Date: 06/11/2024 |
|---|-------------------------------------|-----------------------------------|--------------------------------------|

PURPOSE:

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

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 lingular 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⁾.
 - 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⁾

Medical Necessity Guideline: STAR, CHIP, STAR Kids

Confidential: For use only by employees and authorized agents of Driscoll Health Plan. This document contains confidential and proprietary information NOT to be reproduced or distributed to others without the prior written consent of Driscoll Health Plan

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

Medical Necessity Guideline: STAR, CHIP, STAR Kids

Confidential: For use only by employees and authorized agents of Driscoll Health Plan. This document contains confidential and proprietary information NOT to be reproduced or distributed to others without the prior written consent of Driscoll Health Plan

Driscoll Health Plan Medical Necessity Guideline

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⁾

Medical Necessity Guideline: STAR, CHIP, STAR Kids

Confidential: For use only by employees and authorized agents of Driscoll Health Plan. This document contains confidential and proprietary information NOT to be reproduced or distributed to others without the prior written consent of Driscoll Health Plan

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. Ankyloglossia: To Clip or Not to Clip? That’s the Question. Ann W. Kumer. The ASHA Leader, 1 December 2005.
<https://leader.pubs.asha.org/doi/full/10.1044/leader.FTR2.10172005.6>. Accessed 5/20/2022.
2. Clinical Consensus Statement: Ankyloglossia in Children. Messner AH, Walsh J, Rosenfeld RM, Schwartz SR, Ishman SL, Baldassari C, Brietzke SE, Darrow DH, Goldstein N, Levi J, Meyer AK, Parikh S, Simons JP, Wohl DL, Lambie E, Satterfield L. *Otolaryngol Head Neck Surg*. 2020 May;162(5):597-611. doi: 10.1177/0194599820915457. Epub 2020 Apr 14.
3. Mills N, Pransky SM, Geddes DT, Mirjalili SA. What is a tongue tie? Defining the anatomy of the in-situ lingual frenulum. *Clin Anat* 2019; 32:749.
4. DynaMed [Internet]. Ipswich (MA): EBSCO Information Services. 1995 - . Record No. T114501, Neonatal Ankyloglossia; [updated 2018 Nov 30, cited Corpus Christi, Texas, May 31, 2024]. Available from <https://www.dynamed.com/topics/dmp~AN~T114501>. Registration and login required.

Medical Necessity Guideline: STAR, CHIP, STAR Kids

Confidential: For use only by employees and authorized agents of Driscoll Health Plan. This document contains confidential and proprietary information NOT to be reproduced or distributed to others without the prior written consent of Driscoll Health Plan

Driscoll Health Plan Medical Necessity Guideline



5. Ricke LA, Baker NJ, Madlon-Kay DJ, DeFor TA. Newborn tongue-tie: prevalence and effect on breastfeeding. *J Am Board Fam Pract* 2005; 18:1.
6. Fitz-Desorgher R. (2003). All tied up. Tongue-tie and its implications for breastfeeding. *Practicing Midwife* 2003, 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 Dental Journal*, 34 (8), 479–481.
8. Brinkmann S, Reilly S, Meara JG. Management of tongue-tie in children: a survey of paediatric surgeons in Australia. *J Paediatr Child Health* 2004; 40:600
9. O'Shea JE, Foster JP, O'Donnell CP, et al. Frenotomy for tongue-tie in newborn infants. *Cochrane Database Syst Rev*. 2017;3(3):CD011065. Published 2017 Mar 11. doi:10.1002/14651858.CD011065.pub2.

DOCUMENT HISTORY:

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

Medical Necessity Guideline: STAR, CHIP, STAR Kids

Confidential: For use only by employees and authorized agents of Driscoll Health Plan. This document contains confidential and proprietary information NOT to be reproduced or distributed to others without the prior written consent of Driscoll Health Plan

Driscoll Health Plan Medical Necessity Guideline

| <i>Document Owner</i> | <i>Organization</i> | <i>Department</i> |
|------------------------------------|----------------------|------------------------|
| Dr. Fred McCurdy, Medical Director | Driscoll Health Plan | Utilization Management |

| <i>Review/Revision Date</i> | <i>Review/Revision Information, etc.</i> |
|-----------------------------|--|
| 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. Akhtar |
| 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 Perz and Fred McCurdy |

Medical Necessity Guideline: STAR, CHIP, STAR Kids

Confidential: For use only by employees and authorized agents of Driscoll Health Plan. This document contains confidential and proprietary information NOT to be reproduced or distributed to others without the prior written consent of Driscoll Health Plan