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Related Clinical Coverage Policies

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:
4A, Dental Services

1.0 Description of the Procedure, Product, or Service

Surgery of the lingual frenulum includes incision, excision, or surgical alteration of a short frenulum (otherwise known as ankyloglossia, tongue-tie, or high frenulum attachment) in order to free the tongue and allow greater range of motion.

1.1 Definitions

Tongue-tie or ankyloglossia means a condition that restricts the tongue's range of motion.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term "Specific" found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing*

Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Surgery of the lingual frenulum is covered when

- a. there is evidence of recession in the gingival tissues adjacent to the lower anterior teeth,

OR

- b. the tongue-tip cannot extend upward to the posterior alveolar ridge and/or molars, or the anterior alveolar ridge and/or incisors;

AND

- c. there is significant dysfunction in feeding, speaking, or maintaining oral hygiene, as indicated by medical record or dental record documentation of one of the following:
 1. the type of feeding difficulty, beneficiary's height and weight (when ankyloglossia treatment is indicated due to an impact upon growth), and the results of other treatment measures attempted; or

2. the severity of the articulation disorder, as determined by a formal speech/language evaluation; or
3. the oral hygiene issues involved, and the results of other treatment measures attempted.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Prior approval is required for beneficiaries over 1 year of age.

5.2 Prior Approval Requirements

5.2.1 Prior Approval for Beneficiaries over 1 Year of Age

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request;
- b. all health care records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy; and
- c. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

5.2.2 Prior Approval for Beneficiaries 1 Year of Age or Younger

Prior approval is not required for beneficiaries 1 year of age or younger when all of the following conditions are met:

- a. the criteria in **Section 3.0** are met, and a diagnosis of Tongue tie (Ankyloglossia) describes the condition of the beneficiary,
- b. the procedure to be performed is one of the following:
 1. incision of lingual frenulum (frenotomy);
 2. excision of lingual frenum (frenectomy); **or**
 3. surgical revision of frenum, eg, with Z-plasty (frenuloplasty)

AND

4. The procedure is performed in the **physician's office or dentist's office only.**
- c. Prior approval is not required for newborns with ankyloglossia and feeding difficulties while in the hospital after delivery and beneficiaries 1 year of age or younger diagnosed with ankyloglossia and feeding difficulties while in the hospital for another unrelated procedure, as long as the procedure is performed prior to discharge from the hospital.

5.3 Lifetime Limit

Surgery of the lingual frenulum is limited to once per lifetime.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1974

Revision Information:

Date	Section Revised	Change
04/01/2004	Sections 1.0, 3.0, and 5.0	Added "stripping of tissues lingual to lower anterior teeth"
04/01/2004	Section 5.1	Exempted recipients \leq 30 days of age from PA for 41010 or 41115 when 750.0 and 779.3 are on claim.
04/01/2004	Section 6.0	Added dentists
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The web address for DMA's EPSDT policy instructions was added to this section.
11/01/2006	Sections 2.0 through	A special provision related to EPSDT was added.

	5.0	
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
07/01/2007	Subsection 3.1	General coverage criteria were added to the policy.
07/01/2007	Subsection 3.2	The specific coverage criteria were revised.
07/01/2007	Subsection 4.1	The general coverage criteria were revised.
07/01/2007	Section 5.0	Prior approval requirements were clarified.
07/01/2007	Subsection 8.3	Dental codes were added to the policy.
07/01/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2012	Subsection 5.1	Require PA for recipients over 1 year of age.
07/01/2012	Subsection 5.2	Exempted recipients 1 year of age or younger from PA for 41010 or 41115 when 750.0 is on the claim.
07/01/2012	Subsection 5.2	Removed diagnosis code 779.3 to describe condition of infant.
07/01/2012	Section 1.0	Added (otherwise known as ankyloglossia, tongue-tie, or high frenulum attachment)
07/01/2012	Subsection 1.1	Added Definition, Tongue-tie or ankyloglossia means a condition that restricts the tongue's range of motion
07/01/2012	Subsection 5.2.2	Deleted "the" and added "a diagnosis of Tongue tie (Ankyloglossia)"
07/01/2012	Subsection 5.2.2	Added 3. surgical revision of frenum, eg, with Z-plasty (frenuloplasty)
07/01/2012	Subsection 5.2.2	c. Prior approval is not required for newborns with ankyloglossia and feeding difficulties while in the hospital after delivery and recipients 1 year of age or younger diagnosed with ankyloglossia and feeding difficulties while in the hospital for another unrelated procedure, as long as the procedure is performed prior to discharge from the hospital.
08/15/2012	Subsection 5.2.2	Replaced "infant" with "beneficiary."
08/15/2012	Throughout	Replaced "recipient" with "beneficiary."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service.

ICD-10-CM Code(s)		
Q38.1	P92.3	P92.8
P92.1	P92.4	P92.9
P92.2	P92.5	

Dental providers should refer to clinical coverage policy 4A, *Dental Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>, for the specific covered codes and billing guidelines.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)	HCPCS Code(s)
41010	D7960
41115	D7963
41520	

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient, Outpatient, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at
<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at
http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>.