

Dental Clinical Policy: Excision of Soft Tissue

Reference Number: CP.DP.30

Last Review Date: 11/21

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Description

Excision of soft tissue is a surgical procedure used to manage soft tissue growths on alveolar ridges, tuberosities, or the hard palate, typically a result of inflammatory response to an ill-fitting prosthesis. Inflamed or hypertrophied tissue may also be found surrounding partially erupted/impacted teeth, compromised teeth with fractures, or restorations producing areas of soft tissue impingement/irritation. Concern should also be directed at the possibility of an aggressive or neoplastic process present requiring further diagnosis and treatment.

Policy/Criteria

- I. It is the policy of Envolve Dental Inc.[®] that excision of soft tissue is **medically necessary** when any of the following conditions are met:
 - A. When excess soft tissue growth on the alveolar ridge, tuberosity, and/or hard palate results from an ill-fitting dental prosthesis, and prior to a reline or new prosthesis;
 - B. When the presence of recurrent inflamed or hypertrophied tissue exists around partially erupted/impacted/compromised teeth and teeth are planned for retention;
 - C. When excess fibrous tissue is present on a tuberosity and results in a functional disturbance related to mastication, swallowing, speech, or interferes with the fabrication of a prosthesis;
 - D. Does not have any of the following contraindications:
 1. When medically compromised patients or those taking certain medications (anticoagulants/chemotherapy agents/immunosuppressive agents, etc.) are at high risk for uncontrolled bleeding, infection, or compromised healing;
 2. When the intended soft tissue for removal is in close proximity to vasculature and nervous structures and treatment poses the risk of permanent damage to nervous/vascular tissues during the incision and drainage process;
 - E. Required documentation to support medical necessity include the following:
 1. Clinical chart and treatment notes documenting conditions listed in the indications for the use of excision of soft tissue;
 2. Recent (within the past six months) panoramic radiographic image;
 3. Photographic images of the excess soft tissue;
 4. Consideration should be given for submitting tissue for histopathologic review if conditions are suggestive of an aggressive or neoplastic process.

Coverage Limitation/Exclusions

- I. One D7970 per arch per 36 months.
- II. One D7971 per tooth per 12 months
- III. One D7972 per maxillary quadrant per lifetime
- IV. Subject to state-specific regulations.

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Coding Implications

This clinical policy references Current Dental Terminology (CDT®). CDT® is a registered trademark of the American Dental Association. All CDT codes and descriptions are copyrighted 2020, American Dental Association. All rights reserved. CDT codes and CDT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CDT® Codes	Description
D7970	Excision of hyperplastic tissue – per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M26.01	Maxillary hyperplasia
M26.03	Mandibular hyperplasia
M26.07	Excessive tuberosity of jaw
M26.71	Alveolar maxillary hyperplasia
M26.72	Alveolar mandibular hyperplasia
M26.79	Other unspecified alveolar anomalies
M26.81	Anterior soft tissue impingement
M26.82	Posterior soft tissue impingement
K01.1	Impacted teeth
K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8	Other specified orders of gingiva and edentulous alveolar ridge
K00.6	Disturbances in tooth eruption
K13.4	Granuloma and granuloma-like lesions of oral mucosa
K13.5	Oral submucous fibrosis
K13.6	Irritative hyperplasia of oral mucosa
K13.79	Other lesions of oral mucosa

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	10/20	10/20
Annual Review	11/21	11/21

References

1. American Dental Association. CDT 2020: Dental Procedure Codes. American Dental Association, 2020.
2. Hupp, J., Tucker, M., & Ellis, E. (2018). Contemporary Oral and Maxillofacial Surgery. St. Louis, Mo: Mosby Elsevier.
3. Lindhe, J., Lang, N. P., & Karring, T. (2015). Clinical periodontology and implant dentistry. Oxford: Blackwell Munksgaard.
4. Ness G. (2016). Atlas of Oral and Maxillofacial Surgery, 1st ed. St. Louis, Mo: Mosby Elsevier.
5. Newman, M. G., Takei, H. H., Klokkevold, P. R., & Carranza, F. A. (2012). Carranza's clinical periodontology. St. Louis, MO: Saunders Elsevier.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Envolve Dental makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. “Envolve Dental” means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Envolve Dental retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care, and are solely responsible for the dental and medical advice and treatment of members. This clinical

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policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom Envolve Dental has no control or right of control. Providers are not agents or employees of Envolve Dental.

This clinical policy is the property of Envolve Dental. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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