Clinical Policy: Frenotomy and Frenectomy with Breastfeeding Support

Reference Number: WA.CP.MP.538
Last Review Date: 05/2026
Effective Date: 07/01/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for frenotomy and frenectomy with breastfeeding support for infants.

Frenotomy and frenectomy with breastfeeding support are surgical procedures to release restrictive lingual frenulum in infants with symptomatic ankyloglossia when breastfeeding difficulties persist despite lactation support.

Background

This policy is based on Washington State Health Care Authority (HCA) Health Technology Clinical Committee (HTCC) for Frenotomy and Frenectomy with Breastfeeding Support and Billing Guidelines.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc. and Coordinated Care Corporation, in accordance with the Health Care Authority's Health Technology Clinical Committee and Billing Guidelines, that lingual frenotomy with breastfeeding support is **medically necessary** for members 0-12 months when the following conditions are met:

1. Symptomatic ankyloglossia not improved with lactation support, AND
2. Other causes of breastfeeding problems have been evaluated and treated, AND
3. Performed or referred by a primary care provider with expertise in caring for newborns and providing ongoing care for the infant

II. It is the policy of Coordinated Care of Washington, Inc. that labial frenotomy with breastfeeding support is **not medically necessary**

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT 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.

CPT® Codes	Description
40806	INCS LABIAL FRENUM
40819	EXC FRENUM LABIAL/BUCCAL
41010	INCS LINGUAL FRENUM
41115	EXC LINGUAL FRENUM
41520	FRENOPLASTY

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	5/1	7/26

References

1. Washington State Health Care Authority. Physician-Related Services/Health Care Professional Services billing guide. Revision effective April 1, 2026.

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 medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan 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 medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to 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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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

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Note: For Medicaid members/enrollees, 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.

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