Clinical Review Criteria Related to Orthognathic Surgery

I. Procedure

Orthognathic surgery is medically necessary for correction of skeletal deformities of the maxilla or mandible when it is documented that these skeletal deformities are contributing to significant masticatory dysfunction, and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics.

II. Criteria for Approval

A. Both of the following must be met:

1. Any one of the following facial skeletal deformities is present:

   a. Anteroposterior discrepancies
      • Maxillary/mandibular incisor relationship: overjet of 5 mm or more, or a zero to a negative value (norm = 2 mm).
      • Maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm = 0-1 mm).

   b. Vertical discrepancies:
      • Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks.
      • Open bite with no vertical overlap of anterior teeth greater than 2 mm or unilateral or bilateral posterior open bite greater than 2 mm.
      • Deep overbite with impingement of palatal soft tissue.
      • Supraeruption of a dentoalveolar segment due to lack of opposing occlusion creating dysfunction not amenable to conventions prosthetics.

   c. Transverse discrepancies:
      • Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms.
      • Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.
d. Asymmetries:
   • Anteroposterior, transverse or lateral asymmetries greater than 3 mm, with concomitant occlusal asymmetry.

2. Any one of the following functional impairments if present:
   a. Persistent difficulties with mastication and swallowing after causes such as neurological or metabolic diseases have been excluded.
   b. Malnutrition related to an inability to masticate properly when both of the following are met: significant weight loss for greater than 4 months; and low serum albumin related to malnutrition.
   c. Failure to thrive secondary to facial skeletal deformity.
   d. Myofascial pain secondary to facial skeletal deformity that has persisted for at least six months, despite conservative treatment such as physical therapy and splints.
   e. Airway obstruction, such as obstructive sleep apnea, when documented by polysomnogram where conservative treatment such as continuous positive airway pressure (CPAP) or an oral appliance has been attempted and failed, despite patient compliance.
   f. Speech dysfunction directly related to jaw deformity as determined by a speech and language pathologist.

III. Required Documentation

A. Medical history and physical examination with reference to symptoms related to the orthognathic deformity.

B. Description of specific anatomic deformity present.

C. Copy of medical records from treating physician documenting evaluation, diagnosis and previous management of the functional medical impairments.
D. Physical evidence of a skeletal, facial or craniofacial deformity defined by diagnostic imaging and photos.

E. Detailed description of the functional impairment considered to be the direct results of the skeletal abnormality.

IV. What is Not Covered

A. Expenses associated with orthodontics.

B. Surgical procedures such as rhinoplasty, genioplasty or rhytidectomy performed in conjunction with orthognathic surgery for the sole purpose of improving patient appearance and profile, because they are considered cosmetic in nature and not medically necessary.

C. The use of condylar positioning devices in orthognathic surgery experimental/investigational because their effectiveness in orthognathic surgery has not been established.

D. Surgery for torus mandibularis and torus palatinus for fabrication of partial or full dentures.

E. Orthognathic surgery for correction of temporomandibular joint disease or myofascial pain dysfunction is considered experimental/investigational because its effectiveness for these indications has not been established.

V. CPT/ICD-10/HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

**CPT Codes:**

- 21110 Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
- 21125 Augmentation, mandibular body or angle; prosthetic material
- 21127 Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
- 21141 Reconstruction midface, LeFort1; single piece, segment movement in any direction (e.g., for long face syndrome)
21142  Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft

21143  Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction without bone graft

21145  Reconstruction midface, LeFort I; single piece, segment in any direction, requiring bone grafts (includes obtaining autografts)

21146  Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)

21147  Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies

21150  Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)

21151  Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)

21154  Reconstruction midface, LeFort III; (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I

21155  Reconstruction midface, LeFort III; (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I

21159  Reconstruction midface, LeFort III; (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I

21160  Reconstruction midface, LeFort III; (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I

21188  Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)

21193  Reconstruction of mandible rami; horizontal, vertical, C, or L osteotomy; without bone graft

21194  Reconstruction of mandible rami; horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)

21195  Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation

21196  Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation

21198  Osteotomy, mandible, segmental

21206  Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)

21208  Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

21209  Osteoplasty, facial bones; reduction
21210  Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215  Graft, bone; mandible (includes obtaining graft)
21247  Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)

VI. References

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A

(Last Accessed 2/28/17)

Available at: http://emedicine.medscape.com/article/1279747-overview, Updated 12/02/2014
(Last Accessed 2/28/17)

Available at: http://emedicine.medscape.com/article/844837-overview, Updated Feb 12, 2014
(Last Accessed 2/28/17)

VII. Summary of Changes

06/29/2017
• II., Criteria for Approval 2.,
  o b.: Added the underlined, and moved failure to thrive secondary to facial skeletal deformity to 2., c.: Malnutrition related to an inability to masticate properly when both of the following are met: significant weight loss for greater than 4 months; and low serum albumin related to malnutrition
  o 2., c.: Failure to thrive secondary to facial skeletal deformity.

• IV., What is Not Covered Added E: Orthognathic surgery for correction of temporomandibular joint disease or myofascial pain dysfunction is considered experimental/investigational because its effectiveness for these indications has not been established.
• Added new disclaimer, updated references and last accessed dates
VIII. Review Dates

HNE Review Dates: 9/10/13, 9/9/14, 9/8/15, 6/14/16, 5/9/17
MHI Review Dates: 10/23/14, 10/7/15, 6/30/16, 06/29/2017
Medical Guideline Disclaimer
The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by Minuteman. If there is a discrepancy between this policy and a member’s benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.