

Orthognathic Surgery

MEDICAL POLICY NUMBER: 160

Effective Date: 9/1/2026	COVERAGE CRITERIA	2
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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ Commercial

☐ Medicaid/OHP*

☐ Medicare**

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Orthognathic Surgery: Guideline Note 169, OAR 410-123-160

**Medicare Members

This Company policy may be applied to Medicare Plan members only when directed by a separate Medicare policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

COVERAGE CRITERIA

Notes:

- Member benefits, which address coverage or non-coverage of specific orthognathic surgery services, may vary. Member benefit contract language takes precedence over medical policy.
 - This policy does not address orthognathic surgery for the treatment of obstructive sleep apnea (OSA). Please see the medical policy titled “[Sleep Disorder Surgery \(Company\)](#)”.
- I. Orthognathic surgery may be considered **medically necessary** for the treatment of maxillary and/or mandibular facial deformities associated with malocclusion when all of the following criteria are met (A.-C.):
- A. Documentation indicates that facial skeletal deformities contribute to significant functional impairment (e.g. persistent difficulties with speech, swallowing and/or chewing); **and**
 - B. Documentation indicates that impairment is not correctable with non-surgical treatment (e.g. dental therapeutics, orthodontics); **and**
 - C. Skeletal deformity falls under any of the following categories (see “[Definitions](#)” in Policy Guidelines) (1.-4.):
 - 1. Anteroposterior discrepancies with either of the following (a.-b.):
 - a. Maxillary/mandibular incisor relationship: overjet of 5 mm or more, or a 0 to a negative value (norm = 2 mm); **or**
 - b. Maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm = 0 to 1 mm); **or**
 - 2. Vertical discrepancies with any of the following (a.-d.):

- a. Presence of a significant vertical facial skeletal deformity; **or**
 - b. Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm; **or**
 - c. Deep overbite with impingement of palatal soft tissue; **or**
 - d. Supraeruption of a dentoalveolar segment due to lack of occlusion; **or**
 - 3. Transverse discrepancies with either of the following (a.-b.):
 - a. Presence of a significant transverse skeletal discrepancy; **or**
 - b. Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; **or**
 - 4. Asymmetries (anteroposterior, transverse or lateral) greater than 3mm with concomitant occlusal asymmetry.
- II. Orthognathic surgery is considered **not medically necessary** for the treatment of maxillary and/or mandibular facial deformities associated with malocclusion when criterion I. above is not met.
- III. Orthognathic surgery for the treatment of severe malocclusion that contributes to temporomandibular joint (TMJ) syndrome symptoms may be considered **medically necessary** when all of the following criteria are met (A.-C.):
- A. At least one of the following symptoms is present and has persisted for at least 4 months (1.-3.):
 - 1. Painful chewing clearly related to the TMJ; **or**
 - 2. Frequent and significant headaches clearly related to TMJ; **or**
 - 3. Significant temporomandibular joint and/or muscle tenderness; **and**
 - B. Symptoms persist following 4 months of treatment with at least one of the following conservative measures (1.-3.):
 - 1. Elimination of aggravating factors such as gum chewing, chewing hard or tough foods; **or**
 - 2. Use of anti-inflammatory medications, unless contraindicated; **or**
 - 3. Treatment with splint therapy, unless not tolerated; **and**
 - C. Malocclusion or dental misalignment is present and supported by at least one of the following measurements (1.-3.):
 - 1. Mandibular excess or maxillary deficiency with a reverse overjet (ROJ) of at least 3 mm; **or**
 - 2. Maxillary excess or mandibular deficiency with an overjet of at least 6 mm; **or**
 - 3. Open bite of at least 4 mm or deep bite of at least 7mm.
- IV. Orthognathic surgery for the treatment of severe malocclusion that contributes to temporomandibular joint syndrome symptoms is considered **not medically necessary** when criterion III. above is not met.
- V. In accordance with Oregon House Bill 4128, orthodontics (even in association with orthognathic surgery) may be considered **medically necessary** for the treatment of craniofacial anomalies when the services are needed to restore function (e.g., speech, swallowing, chewing).

VI. In accordance with Oregon House Bill 4128, maxillofacial prosthetic services may be considered **medically necessary** as an adjunctive treatment. This means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma, or birth and developmental deformities when such restoration and management are performed for the purpose of any of the following (A.-C.):

- A. Controlling or eliminating infection; **or**
- B. Controlling or eliminating pain; **or**
- C. Restoring facial configuration or functions such as speech swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

Note: See [Policy Guidelines](#) for full description of Oregon House Bill 4128.

Link to [Evidence Summary](#)

POLICY CROSS REFERENCES

- [Administrative Guideline for Dental Services](#), MP186
- [Sleep Disorder Surgery](#), MP179

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

Oregon House Bill 4128¹

743A.150 Treatment of Craniofacial Anomaly

- (1) As used in this section, 'craniofacial anomaly' means a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.
- (2) All health benefit plans, as defined in ORS 743B.005, providing coverage of hospital, surgical or dental services, shall provide coverage for dental and orthodontic services for the treatment of craniofacial anomalies if the services are medically necessary to restore function.
- (3) This section does not require coverage for the treatment of:
 - (a) Developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; or
 - (b) Temporomandibular joint disorder.
- (4) Coverage required by this section may be subject to copayments, deductibles and coinsurance imposed on similar services by the terms of the plan.

743A.148 Maxillofacial Prosthetic Services

- (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits, other than limited benefit coverage, include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

- (2) As used in this section, “maxillofacial prosthetic services considered necessary for adjunctive treatment” means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:
- (a) Controlling or eliminating infection;
 - (b) Controlling or eliminating pain; or
 - (c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.
- (3) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance.

Clinical Documentation Considerations

Clinical documentation submitted in support of orthognathic surgery requests may not use the exact terminology contained within this policy. Equivalent orthodontic, cephalometric, oral and maxillofacial surgery, or craniofacial terminology may be used when supported by objective clinical findings and measurements.

Providers frequently describe skeletal deformities using diagnostic terminology rather than the measurement-based classifications outlined in this policy. Examples of commonly used diagnoses or descriptors that may correspond to the categories described in Criterion I. include, but are not limited to the following:

Anteroposterior Discrepancies

Examples may include:

- Maxillary hypoplasia
- Maxillary deficiency
- Mandibular hypoplasia
- Mandibular deficiency
- Mandibular retrognathia
- Mandibular hyperplasia
- Mandibular prognathism
- Skeletal Class II malocclusion
- Skeletal Class III malocclusion
- Underbite
- Reverse overjet
- Increased overjet
- Dentofacial deformity with anteroposterior skeletal imbalance

Vertical Discrepancies

Examples may include:

- Open bite
- Skeletal open bite
- Anterior open bite
- Posterior open bite
- Deep bite
- Vertical maxillary excess
- Long-face syndrome
- Vertical maxillary deformity
- Apertognathia

Transverse Discrepancies

Examples may include:

- Crossbite
- Posterior crossbite
- Skeletal crossbite
- Transverse maxillary deficiency
- Maxillary constriction
- Narrow maxillary arch
- Significant transverse maxillary arch deficiency

Facial Asymmetry

Examples may include:

- Facial asymmetry
- Mandibular asymmetry
- Maxillary asymmetry
- Occlusal asymmetry
- Hemifacial asymmetry
- Hemifacial microsomia

The presence of one or more of the above diagnoses alone does not establish medical necessity. Objective measurements and documentation of functional impairment must support satisfaction of applicable coverage criteria.

Examples of Supporting Clinical Documentation

Documentation supporting medical necessity may include, as applicable:

- Oral and maxillofacial surgery consultation notes
- Orthodontic consultation notes
- Orthodontic treatment plans
- Cephalometric analyses and tracings
- Panoramic radiographs
- Diagnostic casts, study models, or digital models
- Computed tomography (CT) or cone-beam CT imaging when available
- Intraoral and extraoral clinical photographs
- Measurements of overjet, overbite, open bite, transverse discrepancies, or facial asymmetry
- Documentation demonstrating that orthodontic or other conservative treatment alone is inadequate to correct the underlying skeletal deformity

Documentation of functional impairment may include descriptions of:

- Impaired masticatory function
- Difficulty chewing or incising food
- Dietary modification due to inability to chew solid foods
- Choking or swallowing difficulties related to inadequate mastication
- Chewing-induced trauma to oral soft tissues
- Speech abnormalities attributable to skeletal deformity
- Functional limitations related to malocclusion or dentofacial deformity

When objective measurements are not explicitly documented in a consultation note, measurements contained within orthodontic records, cephalometric analyses, treatment plans, imaging reports, or surgical evaluations may be used in determining whether criteria are met.

Definitions

Class II Malocclusion: A skeletal or dental relationship in which the mandibular dentition is positioned posterior to its normal relationship with the maxillary dentition, commonly associated with mandibular deficiency, mandibular retrognathia, or maxillary excess. Often described clinically as an overbite.

Class III Malocclusion: A skeletal or dental relationship in which the mandibular dentition is positioned anterior to its normal relationship with the maxillary dentition, commonly associated with mandibular prognathism or maxillary deficiency. Often described clinically as an underbite.

Crossbite: An abnormal transverse relationship of the dental arches in which one or more maxillary teeth occlude lingual to their normal relationship with opposing mandibular teeth.

Deep Bite: Excessive vertical overlap of the maxillary and mandibular dentition that may result in soft tissue impingement or functional impairment.

Dentofacial Deformity: An abnormal relationship of the maxilla, mandible, dentition, and/or facial skeleton that may result in malocclusion, facial asymmetry, impaired mastication, swallowing dysfunction, speech abnormalities, or other functional impairment.

Mandibular Prognathism: Excessive forward projection or overdevelopment of the mandible relative to the maxilla.

Mandibular Retrognathia: Posterior positioning or underdevelopment of the mandible relative to the maxilla.

Masticatory Dysfunction: Functional impairment of chewing or food processing attributable to malocclusion or maxillofacial skeletal abnormalities. Clinical manifestations may include difficulty chewing solid foods, impaired incising, dietary modification, or choking related to inadequate mastication.

Maxillary Hypoplasia: Underdevelopment or posterior positioning of the maxilla that may contribute to Class III malocclusion, reverse overjet, crossbite, facial imbalance, or functional impairment.

Open Bite: Lack of normal vertical overlap between opposing teeth when the jaws are closed. May involve the anterior or posterior dentition.

Overjet: The horizontal distance between the maxillary and mandibular anterior teeth. Positive values indicate the maxillary teeth project anterior to the mandibular teeth; negative values indicate reverse overjet.

Skeletal Malocclusion: Malocclusion resulting primarily from an underlying maxillary and/or mandibular skeletal abnormality rather than dental malposition alone.

BACKGROUND

According to the American Association of Oral and Maxillofacial Surgeons, “orthognathic surgery is the surgical correction of abnormalities of the mandible, maxilla, or both.”² The abnormality may be present at birth (i.e., congenital), may become apparent as the patient develops, or may be the result of a traumatic injury. The primary goal of treatment is to improve craniofacial function (e.g., speech, swallowing, and/or chewing) by correcting the underlying skeletal deformity.

CLINICAL EVIDENCE AND LITERATURE REVIEW

CLINICAL PRACTICE GUIDELINES

American Association of Oral and Maxillofacial Surgeons (AAOMS)

In 2025, the AAOMS published clinical practice guidelines addressing recommended criteria for orthognathic surgery.² Authors stated the following:

“Given the relationship between facial skeletal deformities and masticatory dysfunction as well as the limitations of non-surgical therapies to correct these discrepancies, the measurement of these discrepancies must consider dental compensations relating to the malocclusion and the underlying skeletal deformity. Orthognathic surgery may be indicated and considered medically appropriate in the following circumstances:

- A. Anteroposterior discrepancies: established norm = 2mm
 - 1. Maxillary/mandibular incisor relationship
 - a. Horizontal overjet of +5mm or more;
 - b. Horizontal overjet of zero to a negative value;
 - 2. Maxillary/mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm= 0 to 1 mm);
 - 3. These values represent two or more standard deviation from published norms.
- B. Vertical discrepancies
 - 1. Presence of a vertical facial skeletal deformity, which is two or more standard deviations from published norms for accepted skeletal landmarks;
 - 2. Open bite
 - a. No vertical overlap of anterior teeth;
 - b. Unilateral or bilateral posterior open bite greater than 2mm;
 - 3. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch;
 - 4. Supraeruption of a dentoalveolar segment due to lack of occlusion;
- C. Transverse discrepancies
 - 1. Presence of a transverse skeletal discrepancy, which is two or more standard deviations from published norms;
 - 2. Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth;
- D. Anteroposterior, transverse, or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry.

These indications relate verifiable clinical measurements to significant facial skeletal deformities, maxillary and/or mandibular facial skeletal deformities associated with masticatory malocclusion. In addition to the above conditions, orthognathic surgery may be indicated in cases where there are specific documented signs of dysfunction. These may include conditions involving airway dysfunction, such as sleep apnea, temporomandibular joint disorders, psychosocial disorders and speech impairments.”

EVIDENCE SUMMARY

Skeletal deformities can impact craniofacial function (e.g., speech, swallowing, and/or chewing). The goal of orthognathic surgery is to correct the underlying deformity and there is sufficient clinical practice guidelines to support orthognathic surgery for individuals who meet criteria. Therefore, orthognathic surgery and/or maxillofacial prosthetic services may be considered medically necessary.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online [here](#).

BILLING GUIDELINES AND CODING

CODES*		
CPT	21070	Coronoidectomy (separate procedure)
	21081	Impression and custom preparation; mandibular resection prosthesis
	21082	Impression and custom preparation; palatal augmentation prosthesis
	21083	Impression and custom preparation; palatal lift prosthesis
	21085	Impression and custom preparation; oral surgical splint
	21089	Unlisted maxillofacial prosthetic procedure
	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, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
	21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
	21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
	21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
	21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)

	21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
	21150	Reconstruction midface, LeFort II; anterior intrusion (eg, 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 (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
	21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, 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 mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
	21194	Reconstruction of mandibular 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
	21199	Osteotomy, mandible, segmental; with genioglossus advancement
	21206	Osteotomy, maxilla, segmental (eg, 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)
	21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
	21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
	21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
HCPCS	None	

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Oregon House Bill 4128. Chapter 743A — Health Insurance: Reimbursement of Claims 2024 EDITION. https://www.oregonlegislature.gov/bills_laws/ors/ors743A.html. Accessed 7/9/2025.
2. American Association of Oral and Maxillofacial Surgeons. Criteria for Orthognathic Surgery. https://aaoms.org/wp-content/uploads/2025/01/ortho_indications.pdf. Published 2025. Accessed 7/6/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
10/2023	Annual update. Separated policy by line of business.
7/2024	Interim update. Update to criterion I.
9/2024	Annual review. No change to policy criteria or coding. Added evidence summary.
9/2025	Annual review. No changes to criteria or coding.
9/2026	Annual review. No changes to criteria or coding.