

Orthognathic Surgery

MEDICAL POLICY NUMBER: 160

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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, Providence Plan Partners, and Ayin Health Solutions 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.

**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 Treatment: Surgical \(All Lines of Business Except Medicare\)](#)”.
- I. Orthognathic surgery may be considered **medically necessary** to improve function (e.g., speech, swallowing, and /or chewing) through correction of a skeletal deformity which is due to **at least one** of the following (A.-D.):
- A. Craniofacial anomaly which is defined as a physical disorder identifiable at birth that effects the bony structures of the face and head (e.g., cleft lip/palate, craniosynostosis, craniofacial microsomia, and Treacher Collins syndrome); **or**
 - B. Cysts and/or tumors of the jaw; **or**
 - C. Degenerative disease (e.g., osteoradionecrosis); **or**
 - D. Traumatic injury.
- II. 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.
- III. Orthognathic surgery for the treatment of severe malocclusion that contributes to temporomandibular joint syndrome symptoms is considered **not medically necessary and not covered** when criterion II. above is not met.
- IV. Orthognathic surgery is considered **not medically necessary and is not covered** when criterion I. above is not met, including but not limited to developmental maxillofacial conditions that result in overbite, crossbite, malocclusion, or similar developmental irregularities of the teeth.
- 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

- Company [Dental Services: Administrative Guideline](#), MP186
- Medicare [Dental Services: Administrative Guideline](#), MP162

- Company [Sleep Disorder Treatment: Surgical](#), MP179
- Medicare [Sleep Disorder Treatment: Surgical](#), MP244

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 743.730, 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.

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 2020, 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.”

MEDICARE ADVANTAGE

Note: The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare’s definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan’s use of evidence-based processes for policy development.

Under Medicare, only medically reasonable and necessary services are covered (Title XVIII of the Social Security Act, §1862(a)(1)(A)). The Noridian LCD for Plastic Surgery ([L37020](#)) states, “Corrective facial surgery will be considered cosmetic rather than reconstructive when there is no functional impairment present.” However, as of May 24, 2022, no specific Medicare coverage policy or guidance (e.g., manual, national coverage determination [NCD], local coverage determination [LCD] article [LCA], etc.) was identified which addresses orthognathic surgery for the treatment of conditions other than obstructive sleep apnea. In the absence of a NCD, LCD, or other Medicare policy, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*) Thus, the Company medical policy criteria may be applied for medical necessity decision-making.

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be “investigational.” The term “investigational” is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company’s technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5). For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are “not medically reasonable or necessary” for Medicare Plan members. (*Medicare Claims Processing Manual, Ch. 23, §30 A*)

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 2019 EDITION. https://www.oregonlegislature.gov/bills_laws/ors/ors743A.html. Accessed 5/24/2022.
2. American Association of Oral and Maxillofacial Surgeons. Criteria for Orthognathic Surgery. https://www.aoms.org/docs/practice_resources/clinical_resources/ortho_criteria.pdf. Published 2020. Accessed 7/7/2022.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.

