Medical Policy:
Orthognathic Surgery (Commercial)

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MG.MM.SU.59as2</td>
<td>03/08/2019</td>
<td>MPC (Medical Policy Committee)</td>
</tr>
</tbody>
</table>

**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including 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). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular 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 ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

**Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthognathic surgery</td>
<td>A class of surgical procedures designed to realign the maxillofacial skeletal structures with each other and with the other craniofacial structures. This surgery usually involves the maxilla and/or mandible, but other bony components may be involved as well. Orthognathic surgery can be performed to correct malocclusion, which cannot be improved with routine orthodontic therapy and where the functional impairments are directly caused by the malocclusion. The surgical goal is to improve function through correcting the underlying skeletal deformity that contributes to chewing, breathing and swallowing dysfunction.</td>
</tr>
<tr>
<td>Maxillary advancement</td>
<td>A type of orthognathic surgery that may be necessary to improve the facial contour and normalize dental occlusion when there is a relative deficiency of the midface region. This is done by surgically moving the</td>
</tr>
</tbody>
</table>
Orthognathic Surgery

Medical Guideline

Cosmetic Surgery Procedures

Related Medical Guidelines
Cosmetic Surgery Procedures
Obstructive Sleep Apnea Diagnosis and Treatment

Guideline

Note: Expenses associated with the pre-and-post surgical orthodontic component of are considered dental in nature and not covered under the member’s Medical Benefit.

I. Orthognathic surgery is medically necessary for correcting the following skeletal deformities of the maxilla or mandible when the deformities are directly attributable to significant dysfunction that precludes dental/orthodontic therapeutics or when intra-oral trauma to soft tissues occurs through mastication secondary to malocclusion:

A. Anteroposterior discrepancies defined as either:

1. Maxillary/mandibular incisor relationship; any:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandibular surgery</td>
<td>Can be performed in conjunction with or separate from maxillary surgery. The mandible can be advanced, set back, tilted or augmented with bone grafts. A combination of these procedures may be necessary. Following any significant surgical movement of the mandible, fixation may be accomplished with mini-plates and screws or with a combination of interosseous wires and intermaxillary fixation (IMF). Rigid fixation (screws and plates) has the advantage of needing limited or no IMF. However, if interosseous wiring is used, IMF is maintained for approximately 6 weeks.</td>
</tr>
<tr>
<td>Malocclusion</td>
<td>Imperfect contact with the mandibular and maxillary teeth. • Class II malocclusion: Occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw or an excess of the upper jaw, and therefore, presents two types: (1) Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth. (2) Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards. Commonly referred to as an overbite. • Class III malocclusion: Occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an underbite.</td>
</tr>
<tr>
<td>Occlusion</td>
<td>Bringing the opposing surfaces of the teeth of the two jaws (mandible and maxilla) into contact with each other.</td>
</tr>
<tr>
<td>Supraeruption</td>
<td>The occurrence of a tooth continuing to grow out of the gum if the opposing tooth in the opposite jaw is missing.</td>
</tr>
<tr>
<td>Genioplasty</td>
<td>Plastic surgery of the chin (See Limitations/Exclusions)</td>
</tr>
</tbody>
</table>
Medical Policy:
Orthognathic Surgery (Commercial)

a. Horizontal overjet of $\geq 5$ millimeter (mm)
b. Zero to a negative value (norm 2mm)
2. Maxillary/mandibular anteroposterior molar relationship discrepancy of $\geq 4$ mm (norm is 0–1 mm)

*Numeric values above represent $\geq 2$ standard deviations (SDs) from published norms.*

B. **Vertical discrepancies; defined as any:**
   1. Vertical facial skeletal deformity of $\geq 2$ SDs from norms for accepted skeletal landmarks
   2. Open Bite; either:
      a. No vertical overlap of anterior teeth
      b. Unilateral or bilateral posterior open bite $> 2$ mm
   3. Deep overbite with impingement or irritation of buccal, palatal or lingual soft tissues of the opposing arch
   4. Supraeruption of a dentoalveolar segment secondary to lack of opposing occlusion that creates dysfunction not amenable to conventional prosthetics

C. **Transverse discrepancies; defined as either:**
   1. Transverse skeletal discrepancy $\geq 2$ SDs from norms
   2. Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of $\geq 4$ mm, or unilateral discrepancy $\geq 3$ mm (given normal axial inclination of the posterior teeth)

D. **Asymmetries; defined as anteroposterior, transverse or lateral asymmetries $> 3$ mm with concomitant occlusal asymmetry**

II. **Facial Skeletal Discrepancies Associated with Documented Sleep Apnea, Airway Defects, and Soft Tissue Discrepancies**

Orthognathic surgery is considered medically necessary for members with underlying congenital and acquired (i.e., post-traumatic or post-ablative) craniofacial skeletal deformities that are contributing to obstructive sleep apnea (see [Obstructive Sleep Apnea](#)) or other demonstrated significant functional deficiency.

III. **Speech Impairments**

Orthognathic surgery is medically necessary for the treatment of speech abnormalities (as determined by a speech pathologist or therapist) when the impairment is secondary to a malocclusion (e.g., from cleft deformity), which is refractory to either:

1. Orthodontia management
2. At least 6 months of speech therapy

**Documentation**
The following documentation must be submitted to the plan for medical necessity consideration:

1. Evidence of skeletal, facial or craniofacial deformity demonstrated by study models and pre-orthodontic photographic and radiographic imaging
Medical Policy: Orthognathic Surgery (Commercial)

2. Medical record detailing the following:
   a. Objective findings (i.e., functional impairment directly attributable to skeletal abnormality)
   b. Symptoms (e.g., dysphagia, choking), clinical course/treatment history

Limitation/Exclusion

1. Orthognathic surgery is considered cosmetic (and therefore not medically necessary) when anatomic variation is normal and the member wishes to alter physical appearance in order to improve aesthetics. (Psychological motivation [e.g., self esteem] is not a factor for plan-consideration).
2. Three-dimensional virtual treatment planning of orthognathic surgery regarded as investigational and not medically necessary, as effectiveness has not been established.
3. Orthognathic surgery is considered investigational for correcting articulation disorders (except in the presence of severe cleft palate; indicated above) and other impairments in the production of speech due to insufficient evidence of therapeutic value in the published peer-reviewed medical literature.
4. Orthognathic surgery is not considered medically necessary the correction of sibilant sound-class distortions or other speech quality distortions (e.g., hyper-nasal or hypo-nasal speech) because the distortions do not cause functional impairment.
5. Condylar positioning devices in orthognathic surgery are experimental and investigational because their effectiveness in orthognathic surgery has not been established
6. Orthognathic surgery for temporomandibular joint disease (TMJ) or myofascial pain dysfunction is considered investigational due to insufficient evidence of therapeutic value for these indications.
7. Genioplasty is considered cosmetic and not medically necessary

Coding Criteria
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

| Applicable CPT and Diagnosis Codes |

References


Medical Policy:
Orthognathic Surgery (Commercial)


Specialty matched clinical peer review.
Orthognathic Surgery


Revision history

<table>
<thead>
<tr>
<th>DATE</th>
<th>REVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/09/2019</td>
<td>Reformatted and reorganized policy, transferred content to new template</td>
</tr>
<tr>
<td>03/08/2019</td>
<td>Added &quot;palatal&quot; to vertical discrepancies definition related to deep overbite</td>
</tr>
<tr>
<td></td>
<td>Added congenital, acquired, or other demonstrated significant functional deficiency, that contributes to obstructive sleep apnea (regarding craniofacial skeletal deformities)</td>
</tr>
<tr>
<td></td>
<td>Added photographic to documentation section</td>
</tr>
</tbody>
</table>