Clinical Policy: Orthognathic Surgery

Reference Number: IL.CP.MP.511
Last Review Date: 09/21

Coding Implications
Revision Log

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

Description

Orthognathic surgery is the surgical correction of abnormalities of the mandible, maxilla, or both. The underlying abnormality may be present at birth or may become evident as the patient grows and develops or may be the result of traumatic injuries. The severity of these deformities precludes adequate treatment through dental treatment alone.

Anteroposterior discrepancy	Anatomical issue regarding maxilla and mandible in front to back relationship o Overjet: abnormality of horizontal incisor relationship / horizontal overlap between upper and lower teeth. o Overbite: abnormality of vertical incisor relationship / vertical overlap between upper and lower teeth.
Vertical discrepancies	Anatomical issue regarding maxilla and mandible height, up and down relationship
Transverse discrepancy	Anatomical issue regarding maxilla and mandible in transverse plane (side to side issue)
Unilateral discrepancy	Anatomical issue only affecting one side of the mouth
Open bite	Anterior teeth do not overlap, a malocclusion in which the teeth do not close or come together in the front of the mouth
Supraeruption	Individual teeth emerge too far from the bone in jaw, teeth project too far into the mouth
Dentoalveolar segment	Larger segment of teeth and supporting structure
Axial inclination	A plane parallel to the surface of a tooth, usually described in mediodistal or faciolingual anteroposterior, transverse, lateral, occlusal asymmetries
Class occlusion/malocclusions	o Class I: Exists with the teeth in a normal relationship when the mesial-buccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar o Class II: Malocclusion occurring when the mandibular teeth are behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw (Type 1) or an excess of the upper jaw (type 2) o Class III: Commonly referred to as an under bite. 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.
Mentoplasty or genial osteotomies/ostectomies	Surgery on the chin
Myofacial Pain Syndrome	Regional pain with associated trigger points, taut bands, and pressure sensitivity has been called myofascial pain

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that orthognathic surgery is **medically necessary** when documentation meets the health plan policy indications below. Please note that members with congenital anomalies including, but not limited to, cleft lip / cleft palate, midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome, will be considered for orthognathic surgery if they meet one of the criteria listed.

II. **Facial Skeletal Deformities:** Indications based on facial skeletal deformity. If the criteria are not met, then the procedure is considered not medically necessary for **any of the following (A-E)**

A. **Anteroposterior discrepancies – any <u>one</u> of the following:**
   i. Mandibular maxillary relationships established norm=2mm
      1. Horizontal overjet of 5 mm or more; ***or***
      2. Horizontal overjet of zero to a negative value
   ii. Maxillary/mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm)

B. **Vertical discrepancies – any <u>one</u> of the following:**
   i. Presence of a vertical facial skeletal deformity, which is two or more standard deviations from published norms for accepted skeletal landmarks
   ii. Open bite
      1. No vertical overlap of anterior teeth
      2. Unilateral or bilateral posterior open bite greater than 2 mm
   iii. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
   iv. Supraeruption of a dentoalveolar segment due to lack of occlusion.

C. **Transverse discrepancies - any <u>one</u> of the following:**
   i. Presence of a transverse skeletal discrepancy, which is two or more standard deviations from published norms
   ii. 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**
   i. Anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry.

E. **Malnutrition, significant weight loss, or failure-to-thrive secondary to facial deformity – <u>both</u> of the following:**
   i. Height and weight over preceding year along with current weight and height (at least 3 total weights within 1 year); and
   ii. Appropriate labs related to nutritional status, and appropriate endocrine tests such as TSH (albumin, transthyretin/ prealbumin, transferrin, retinal-binding protein (RBP), and growth hormone as indicated

III. **Skeletal deformities related to airway dysfunction:**
   A. Skeletal deformities contributing to medically significant functional impairment with the airway ***or***
   B. Sleep apnea criteria, and **<u>all</u>** of the following:
      i. Symptomatic obstructive sleep apnea indicated by Apnea/Hypopnea Index (AHI) greater than 20 on sleep study ***or***
      ii. Failed two month trial of Continuous Positive Airway Pressure (CPAP) when clinically appropriate and
      iii. Prior to surgical treatment for sleep apnea, such patients should be properly evaluated to determine the cause and site of their disorder with appropriate non-surgical treatment attempted when indicated.
         1. Other common sites of obstruction: nasal, palate, base of tongue, pharyngeal wall

IV. **Facial skeletal discrepancies – resulting in <u>any</u> of the following:**
   A. Documented temporomandibular joint dysfunction (not temporomandibular joint syndrome, see below)
   B. Documented speech dysfunction. Speech therapy evaluation must be performed and provided.
   C. Documented severe psychological disorders. Requires evidence of failed psychiatric therapy and recommendations of psychiatrist.

V. **Required Documentation:**
   A. Meridian Health Plan considers Orthognathic Surgery medically necessary for correction of skeletal deformities of the maxilla or mandible when clinical documentation indicates **<u>all</u>** of the below:
      i. A physiological functional impairment that would be improved by Orthognathic Surgery
      ii. Non-surgical treatments, such as dental therapeutics or orthodontics alone, have not adequately treated the condition.
      iii. X-ray reports and/or photos may be requested on a case to case basis to confirm diagnosis/deformity

VI. **Absolute Contraindications:**
   A. Class I occlusion/malocclusions.
   B. Any malocclusion that is correctable by a non-surgical orthodontic or dental procedure
   C. Mentoplasty or genial osteotomies/ostectomies (chin surgeries) or implants are considered cosmetic when performed as an isolated procedure to address genial hypoplasia, hypertrophy, or asymmetry. These procedures may be considered cosmetic when performed with other surgical procedures for correction of

functional issues with skeletal deformities and will be reviewed for medical necessity.

D. Surgical adjustment of facial balance or facial proportion in the absence of skeletal functional impairment is considered cosmetic.

Orthognathic surgery for Myofascial Pain Dysfunction (MPD) Syndrome is considered Investigational and Experimental. Myofascial, neck, head, and shoulder pain are common symptoms of this disorder.

VII. Non-covered Benefits

A. The following are not covered a covered benefit:
   i. Orthodontic treatment in preparation for medically necessary orthognathic surgery and is not a covered benefit.
   ii. Dental implants (including the implanted tooth posts) for any Orthognathic procedure
   iii. Three dimensional virtual treatment planning for orthognathic surgery is considered experimental and investigational
   iv. Orthognathic surgery is not medically and not a covered benefit for the sole purpose of improving individual appearance of the member, regardless of whether they are associated with psychological disorders, because they are considered cosmetic in nature.

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 2019, 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

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Revisions Date	Approval Date
Original approval date		4/24/09
Annual Review	09/21	09/21

References

1. American Association of Oral and Maxillofacial Surgeons. Clinical Paper Criteria for Orthognathic Surgery. Revised 2020. https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Practitioner.aspx.
2. American Association of Oral and Maxillofacial Surgeons. Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery. Version Date: 2012
3. Miloro, Michael, DMD, MD. "Mandibular Distraction Osteogenesis for Pediatric Airway Management". J Oral Maxillofac Surg 68:1512-1523, 2010
4. Antje Lindenmeyer, PhD, MA,* Paul Sutcliffe, DPhil, BSc,Mehri Eghtessad, MSc, LDSRCS, et. Al. "Oral and Maxillofacial Surgery and Chronic Painful Temporomandibular Disorders – A Systematic Review". J Oral Maxillofac Surg 68:2755-2764, 2010
5. Greene, Charles S, DDS, Obrez, Ales, DMD PhD. "Treating temporomandibular disorders with permanent mandibular repositioning: is it medically necessary?" Oral Surg Oral Med Oral Pathol Oral Radiol 2015;119:489-499Stokbro K, Aagaard E, Torkov P, et al. Virtual planning in orthognathic surgery. Int J Oral Maxillofac Surg. 2014;43(8):957-965

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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees 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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.