Clinical Policy: Orthognathic Surgery

Reference Number: CP.DP.44
Last Review Date: 12/24

Coding Implications
Revision Log

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

Description

This policy describes the medical necessity requirements for orthognathic surgery.

Policy/Criteria

I. It is the policy of Envolve Dental® that orthognathic surgery is **medically necessary** when all of the following are met:

A. When any of the following skeletal deformities (associated with masticatory malocclusion) are present:

1. Anteroposterior discrepancy, one of the following:
   a. Maxillary/mandibular incisor relationship: overjet of >5 mm, or a zero to negative value (norm = 2 mm);
   b. Maxillary/mandibular anteroposterior molar relationship discrepancy of >4 mm (norm = 0-1 mm);
2. Vertical discrepancy, one of the following:
   a. Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks;
   b. Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2 mm;
   c. Deep overbite with impingement of palatal soft tissue;
   d. Supraeruption of a dentoalveolar segment resulting from lack of occlusion when dentition in segment is intact;
3. Transverse discrepancy, one of the following:
   a. Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms;
   b. Total bilateral 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;
4. Anteroposterior, transverse or lateral asymmetries greater than 3 mm, with concomitant occlusal asymmetry.

B. When any of the following diagnosed functional impairments are present:

1. Persistent difficulties with mastication and swallowing after causes such as neurological or metabolic diseases have been excluded: swallow study or supportive documentation from the patient's physician must be provided;
2. Malnutrition, significant weight loss, or failure-to-thrive secondary to facial skeletal deformity; supportive objective documentation of weight loss or laboratory criteria from the physician or nutritionist that documenting nutrition issues, and the documentation incorporates data that pre-dates the initial consultation with the maxillofacial surgeon must be provided;
3. Speech dysfunction directly related to a jaw deformity as determined by a speech and language pathologist;
4. Myofascial pain secondary to facial skeletal deformity that has persisted for at least six months, despite compliant conservative treatment such as physical therapy and splints;
5. Airway obstruction, such as obstructive sleep apnea diagnosed by an appropriately

licensed provider and documented by polysomnogram, when both of the following criteria are met:

   a. Criteria for positive airway pressure (PAP) met and individual has proved intolerant to or failed a trial of PAP;
   b. Individual has failed prior less invasive surgical procedures OR has craniofacial skeletal abnormalities that are associated with a narrowed posterior airway space and tongue-base obstruction.

II. It is the policy of Envolve Dental® that orthognathic surgery is **not medically necessary when any of the following are present:**

   A. When the sole purpose is to improve individual appearance, regardless of whether they are associated with psychological disorders, because they are considered cosmetic in nature; or
   B. When the patient is still developing and treatment could be corrected with less intrusive treatment (e.g., expander or head gear).

Background

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. Such skeletal abnormalities may cause difficulties with eating or chewing, abnormal speech patterns, or dysfunction of the temporomandibular joint (TMJ). The overall goal of treatment is to improve function through correction of the underlying skeletal deformity.

Abnormalities generally occur as a result of a differential in growth between the upper facial skeleton and the lower facial skeleton, resulting in a discrepancy of the normal relationship that exists between the upper jaw (maxilla) and lower jaw (mandible). Genetic predisposition and acquired causes can influence the normal growth of the facial skeleton from syndromes such as Apert and Crouzon or from facial clefts. Traumatic events can displace the normal structural elements or may disturb future normal growth. Other etiologies that can result in significant dentofacial anomalies include neoplasms, surgical resection and iatrogenic radiation. Developmental anomalies, however, are the most common condition. All of these deformities may result in diminished bite forces, restricted mandibular excursions, abnormal chewing patterns, speech deficits, malocclusions and/or abnormal facial appearance. There is a relationship between facial skeletal abnormalities and malocclusions, including Class II (disto- occlusion), Class III (mesio-occlusion) and open-bite (teeth do not meet) deformities.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) classification of occlusion/malocclusion

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. 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*).

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.

Surgical Procedures

In orthognathic surgery, an osteotomy is made in the affected jaw, and the bones are repositioned in a more normal alignment. The bones are held in position with plates, screws and/or wires. Intermaxillary fixation, a procedure in which arch bars are placed on both jaws, may also be needed to provide added stability. Simultaneous osteotomies may be performed when deformities must be corrected in both jaws. Grafts from the ribs, hip or skull may be performed for patients with deficient bone tissue; alloplastic bone replacement may also be required. Orthognathic surgery is generally performed under general anesthesia on an inpatient basis. Although sometimes performed for cosmetic purposes, orthognathic surgery is generally considered to be medically necessary when performed to treat a significant abnormality that is causing considerable functional impairment.

Coding Implications

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Retrospective review/analysis or fraud, waste and abuse initiatives that identify mis-coding (upcoding) resulting in higher reimbursement than allowed for the correctly coded service, or does not provide documentation supporting performing and/or completing claimed services may result in the recoupment of the identified monetary variance by any of the following means: a) from the payment for other claimed services; or b) directly from the provider.

CDT ®* Codes	Description
D7940	Osteoplasty, for orthognathic deformities
D7941	Osteotomy, mandibular rami
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy, segmented or subapical
D7945	Osteotomy, body of mandible
D7946	LeFort I (maxilla, total)
D7947	LeFort I (maxilla, segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion); without bone graft
D7949	LeFort II or LeFort III; with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or non-autogenous, by report
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7995	Synthetic graft, mandible or facial bones, by report

CDT ®* Codes	Description
D7998	Intraoral placement of a fixation device not in conjunction with a fracture

CPT®* Codes	Description
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; prosthetic; 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; 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 (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
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 (e.g., Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

CPT®* Codes	Description
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (include obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, superiosteal implant; partial
21246	Reconstruction of mandible or maxilla, superiosteal implant; complete
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., 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

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

ICD-10-CM Code	Description
M26.00 - M26.09	Unspecified anomaly of jaw size (M26.00)
M26.10 - M26.19	Unspecified anomaly of jaw-cranial base relationship (M26.10)
M26.20	Unspecified anomaly of Dental Arch Relationship
M26.21 - M26.219	Malocclusion, Angle's Class
M26.220 - M26.29	Open anterior occlusal relationship (M26.220)
M26.30 - M26.39	Unspecified anomaly of Tooth Position of Fully Erupted Tooth or Teeth (M26.30)
M26.4	Malocclusion, Unspecified
M26.50 - M26.59	Dentofacial functional abnormalities, unspecified (M26.50)

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	02/22	02/22
Annual Review	12/22	12/22
Annual Review and Format Change	12/23	12/23
Annual Review	12/24	12/24

References

1. Criteria for orthognathic surgery. American Association of Oral and Maxillofacial Surgeons website. https://www.aaoms.org/docs/practice_resources/clinical_resources/ortho_criteria.pdf. Published 2017. Accessed October 7, 2020.
2. American Dental Association CDT-2024 Code on dental procedures and nomenclature. Delta Dental website. https://www.deltadentalco.com/uploadedFiles/ProviderFeeSchedules/DDCO_Par_Provider_Documents/CDT%202017_Code%20on%20Dental%20Proc_Nomenclature%20online.pdf. Published 01/01/2017. Accessed October 7, 2020.

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.

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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 https://www.cms.gov for additional information.

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