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 Subject: Orthognathic Surgery for Severe Oral-Maxillofacial
 Functional Disorders
 Effective Date: March 1, 2011

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	MD

Note: Background, product, and disclaimer information is located at the end of this document.

Overview

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

Coverage Guidelines

Tufts Health Plan may authorize coverage of orthognathic surgery when one of the following criteria points from **Group One** and one of the functional impairments from **Group Two** are met. Please complete and fax in the [Orthognathic Surgery Request Form](#) when requesting prior authorization.

Group One

Anterior posterior discrepancies

- Maxillary/mandibular incisor relationship: overjet of 5mm or more, or a zero to a negative value (norm 2mm)
- Maxillary /mandibular anterior posterior molar relationship discrepancy of 4mm or more (norm=0-1mm)

Vertical discrepancies

- Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks.
- Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite > 2mm.
- Deep overbite with impingement of palatal soft tissue.
- Supraeruption of a dentoalveolar segment resulting from lack of occlusion when dentition in the segment is intact.

Transverse discrepancies

- Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms.
- 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.

Asymmetries

-Anteroposterior, transverse or lateral asymmetries greater than 3mm, with concomitant occlusal asymmetry.

Group Two

- Significant interference with adequate mastication which leads to malnutrition, significant unintended weight loss or failure to thrive secondary to facial skeletal deformity.
- Speech dysfunction directly related to a jaw deformity as indicated by a speech and language pathologist.
- Myofascial pain secondary to facial skeletal deformity that has persisted for ≥ 6 months despite conservative treatment such as physical therapy and splints.
- Airway obstruction, such as OSA, that is a direct result of the skeletal/jaw deformity.

* Please Note: Tufts Health Plan may cover facial osteotomy when part of an authorized orthognathic procedure.

Limitations

Tufts Health Plan does not cover the treatments listed below.

-Tufts Health Plan does not cover genioplasty, rhinoplasty or otoplasty in conjunction with orthognathic surgery as they are considered cosmetic procedures and are specifically excluded.

-Tufts Health Plan does not cover orthodontic treatment provided as an adjunct to orthognathic surgery, because such treatment is considered dental in nature and, therefore, specifically excluded.

-THP does not cover services pertaining to the development of the surgical treatment plan prior to surgery for orthognathic surgery.

Codes

The following CPT codes require Prior Authorization:

Code	Description
21125	Augmentation, mandibular body or angle; prosthetic material
21127	with bone graft, onlay or interpositional (includes obtaining autograft)
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
21142	two pieces, segment movement in any direction, without bone graft
21143	three or more pieces, segment movement in any direction, without bone graft
21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
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
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)
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)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	Arthroplasty, temporomandibular joint, with allograft
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., 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) (e.g., for hemifacial microsomia)
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete

The following HCPCS codes require Prior Authorization:

Code	Description
D7940	Osteoplasty-for orthognathic deformities
D7941	Osteotomy-mandibular rami
D7943	Osteotomy-mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy-segmental 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 of the mandible or maxilla-autogenous or nonautogenous
D7995	Synthetic graft-mandible or facial bones, by report
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report

The following CPT codes are not covered and deny as not medically necessary:

Code	Description
21280	Medial canthopexy
21282	Lateral canthopexy

References

American Association of Oral and Maxillofacial Surgeons. Criteria for orthognathic surgery. Published 1999. Updated 2008. Accessed Aug 25, 2008. Available at URL address: http://www.aaoms.org/docs/practice_mgmt/ortho_criteria.pdf

National Institutes of Health. "Management of Temporomandibular Disorders". Technology Assessment Statement. May 1, 1996.

National Institute of Dental Research. "Temporomandibular Disorders (TMD)". <http://www.healthsquare.com/nihdental/tmddent.htm>

Approval History

Reviewed by the Clinical Coverage Criteria Committee in February 1999.

Subsequent Endorsement Date(s) and Changes Made:

October 2000: No changes

October 2001: No changes

October 2002: "Trimmed models or photographs of models" was added as a requirement in the report that must be submitted to the Precertification Department

October 28, 2003: Reviewed and renewed, updated to new format

January 9, 2004: Limitation specified

January 7, 2005: Title of criteria changed from Orthognathic Surgery for TMJ or Severe Eating Disorders. Actual models are no longer requested by Tufts Health Plan; instead photographs of models in proper occlusion are now requested.

January 13, 2006: Reviewed and renewed without changes

March 5, 2007: Additional definitions for genioplasty and facial osteotomy added. Coverage of facial osteotomy when done as part of an authorized orthognathic procedure was added. Genioplasty was added to the Limitations.

May 7, 2007: Detail of TMJ Disorder Treatment Limitations and Limitation regarding TMJ appliances, occusal adjustment and other TMJ-related therapies added

April 25, 2008: Reviewed and renewed without changes

August 5, 2009: New and separate guidelines were written for the treatment of TMJ Effective Date January 1, 2010. See Document #2146100.

March 2011: Reviewed by MSPAC, no changes.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.