ORTHOGNATHIC (JAW) SURGERY

Policy Number: SURGERY 069.14 T2 **Effective Date**: October 1, 2018

Table of Contents **Page**

Related Policies

- Obstructive Sleep Apnea Treatment
- Temporomandibular Joint Disorders

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General benefits package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes[1, 2, 3]
Precertification with Medical Director Review Required	Yes[1, 2]
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Outpatient, Office, Inpatient
Special Considerations	[1]Oxford's Dental Department will review requests for services to be rendered by practitioners of the following specialties: oral surgery, oral/maxillofacial surgery, general or pediatric dentistry, endodontics, periodontics, and orthodontics. All other specialties require Medical Director (or designee) review through Oxford's Medical Management Department. [2]Precertification with review by a Medical Director or their designee is required.

Special Considerations *(continued)*	[3]**Participating providers in the office setting**: Precertification is required for services performed in the office of a participating provider. **Non-participating/ out-of-network providers in the office setting**: Precertification is not required, but is encouraged for out-of-network services performed in the office. If precertification is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

Orthognathic (jaw) surgery is a standard exclusion from coverage in most fully-insured plans. The following list represents the covered **exceptions** to the oral surgery exclusion.

The following are eligible for coverage as reconstructive and medically necessary:
- Acute traumatic injury, and Post-Surgical Sequela (please see *Post-Surgical Sequela* in the Definitions section below)
- Cancerous or non-cancerous tumors and cysts, Cancer and Post-Surgical Sequela (please see *Cancer Sequela* and *Post-Surgical Sequela* in the Definitions section below).

The following are eligible for coverage when the criteria are met (see Criteria section below):
- Obstructive sleep apnea (refer to the policy titled Obstructive Sleep Apnea Treatment for additional information)
- Cleft lip/palate (for cleft lip/palate related Jaw Surgery)
- Congenital anomalies that meet the criteria for reconstructive. Depending on a member-specific clinical review, examples include: Pierre Robin Syndrome, Hemifacial Microsomia and Treacher Collins Syndrome.

Criteria

All orthognathic (jaw) surgeries are subject to some level of review. For the above covered exceptions that require review, the following criteria should be applied.

Orthognathic (jaw) surgery is a reconstructive procedure and medically necessary and is considered covered when both the skeletal deformity AND the Functional Impairment criteria below are met:
- The presence of **any** of the following facial **skeletal deformities** associated with masticatory malocclusion:
  - *Anteroposterior Discrepancies (established norm=2mm)*
    - Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value
    - Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more
    - These values represent two or more standard deviation from published norms
  - *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:
      - No vertical overlap of anterior teeth
      - Unilateral or bilateral posterior open bite greater than 2mm
    - Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
    - Supraeruption of a dentoalveolar segment due to lack of occlusion
  - *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
- In addition to meeting the skeletal deformity requirement above, the individual must also have one or more of the following **Functional Impairments**:
    - Masticatory (chewing) and swallowing dysfunction due to skeletal malocclusion (e.g., inability to incise and/or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition)
    - Documentation of speech deficits to support existence of speech impairment skeletal malocclusion
    - Moderate to severe obstructive sleep apnea as measured by polysomnography (AASM Obstructive Sleep Apnea; and Practice Parameters for the Surgical Modifications of the Upper Airway for Obstructive Sleep Apnea in Adults), defined as:
        - Moderate for AHI or RDI ≥ 15 and ≤ 30
        - Severe for AHI or RDI > 30/hr

      and
    - Oropharyngeal narrowing secondary to maxillomandibular deficiency is the primary cause of moderate to severe obstructive sleep apnea. [See MCG™ Care Guidelines, 22nd edition, 2018, Maxillomandibular Osteotomy and Advancement A-0248 (ACG).]

For Obstructive Sleep Apnea

In addition to the criteria above, also refer to the following:

- **Maxillomandibular advancement surgery (MMA)**: For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 22nd edition, 2018, Maxillomandibular Osteotomy and Advancement, A-0248 (ACG).
- **Multilevel procedures whether done in a single surgery or phased multiple surgeries**: There are a variety of procedure combinations, including mandibular osteotomy and genioglossal advancement with hyoid myotomy (GAHM). For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 22nd edition, 2018, Mandibular Osteotomy, A-0247 (ACG).

Coverage Limitations and Exclusions

Except where state mandated, the following are not covered:

- Cosmetic and non-reconstructive Jaw Surgery and jaw alignment procedures (Orthognathic Surgery) that do not meet the criteria in the Indications for Coverage section above are excluded from coverage.
- Surgery for torus mandibularis and torus palatinus for fabrication of dentures is not covered.
- Pre and post-surgical orthodontic treatment.

Additional Information

Some states may require orthognathic (jaw) surgery for cleft lip and cleft palate, or for services that Oxford considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to the member specific benefit plan document.

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Cancer Sequela: An aftereffect resulting from a cancer

Functional/Physical Impairment: A Physical/Functional or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Jaw Surgery: Surgical procedures to address facial trauma, neoplasms, facial clefts, surgical resection and iatrogenic radiation.

Orthognathic Surgery: The surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw) or maxilla (upper jaw). These malformations may be present at birth or may become evident as the individual grows and develops. Causes include congenital or developmental anomalies.

Post-Surgical Sequela: An aftereffect following a surgical procedure.

Sequela: Aftereffect of a disease, condition, or injury.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

Note: The following codes are excluded from coverage. However, there are exceptions to the exclusion that require review. Please see the Indications for Coverage section above for a description of the exceptions.

CPT Code	Description
21076	Impression and custom preparation; surgical obturator prosthesis
21079	Impression and custom preparation; interim obturator prosthesis
21080	Impression and custom preparation; definitive obturator prosthesis
21081	Impression and custom preparation; mandibular resection prosthesis
21082	impression and custom preparation; palatal augmentation prosthesis
21083	Impression and custom preparation; palatal lift prosthesis
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
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 (e.g., 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) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 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 (e.g., 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 (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I

CPT Code	Description
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., 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 (e.g., Wassmund or Schuchard)
21210	Graft, bone; nasal, maxillary or malar areas (includes 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, 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)

CDT Code	Description
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5982	Surgical stent
D5988	Surgical splint
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7490	Radical resection of maxilla or mandible
D7610	Maxilla – open reduction (teeth immobilized, if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7650	Malar and/or zygomatic arch – open reduction
D7671	Alveolus – open reduction, may include stabilization of teeth
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla – open reduction
D7730	Mandible – open reduction
D7750	Malar and/or zygomatic arch – open reduction
D7770	Alveolus – open reduction stabilization of teeth
D7780	Facial bones – complicated reduction with fixation and multiple approaches
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

CDT Code	Description
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 ormaxilla bones – autogenous or nonautogenous, by report
D7953	Bone replacement graft for ridge preservation – per site
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7995	Synthetic graft – mandible or facial bones, by report
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee. [*CDG.013.07*]

American Association of Oral and Maxillofacial Surgeons (AAOMS). Clinical Paper. Criteria for Orthognathic Surgery. 2017.

American Cleft Palate-Craniofacial Association. Parameters for evaluation and treatment of patients with cleft lip/palate or other craniofacial anomalies. March 1993. Revised November 2009.

American Society of Plastic Surgeons (ASPS) available at: http://www.plasticsurgery.org/.

Aurora RN, Casey KR, et al. Practice parameters for the surgical modifications of the upper airway for obstructive sleep apnea in adults. Sleep. 2010 Oct;33(10):1408-13.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

10/01/2018	• Updated conditions of coverage/special considerations; modified notation to clarify:
	  ○ For **participating providers in the office setting**: Precertification is required for services performed in the office of a participating provider
	  ○ For **non-participating/out-of-network providers in the office setting**: Precertification is not required, but is encouraged for out-of-network services performed in the office; if precertification is not obtained, Oxford will review *for out-of-network benefits and* medical necessity after the service is rendered
	• Updated coverage rationale; modified language to clarify the listed MCG™ Care Guidelines should be referenced for medical necessity *clinical coverage criteria*
	• Archived previous policy version SURGERY 069.13 T2