ORTHOGNATHIC (JAW) SURGERY

Guideline Number: MMG095.L **Effective Date**: July 1, 2019

Instructions for Use

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Related Medical Management Guidelines

- Obstructive Sleep Apnea Treatment
- Temporomandibular Joint Disorders

COVERAGE RATIONALE

Orthognathic (jaw) surgery is a standard exclusion from coverage in most fully-insured plans. The following represents exceptions to the orthognathic (jaw) surgery exclusion and **may be** eligible for coverage as reconstructive and medically necessary:

- Acute traumatic injury
- Cancerous or non-cancerous tumors and cysts
- Obstructive sleep apnea
- Congenital defects

Criteria

Orthognathic (jaw) Surgery may be eligible for coverage as reconstructive and medically necessary for the conditions cited above when the following criteria below are met:

- The presence of one or more 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.

  and
- The member 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 due to skeletal malocclusion
  - Moderate to Severe Obstructive Sleep Apnea (OSA) with Oropharyngeal narrowing secondary to maxillomandibular deficiency

For medical necessity clinical coverage criteria for OSA, also refer to the following:

- **Maxillomandibular Advancement Surgery (MMA)**: For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 23rd edition, 2019, 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, 23rd edition, 2019, Mandibular Osteotomy, A-0247 (ACG).

Coverage Limitations and Exclusions

Orthognathic surgery for the following is not covered:

- Cosmetic and non-reconstructive Jaw Surgery and jaw alignment procedures
- Pre and post-surgical orthodontic treatment

DOCUMENTATION REQUIREMENTS

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information
Orthognathic (Jaw) Surgery

Medical notes documenting **all** of the following:
• Comprehensive history of the medical condition(s) requiring treatment or surgical intervention, including all of the following:
  ○ A well-defined physical and/or physiological abnormality (e.g., congenital abnormality, functional or skeletal impairments) resulting in a medical condition that has required or requires treatment; and
  ○ The physical and/or physiological abnormality has resulted in a functional deficit; and
  ○ The functional deficit is recurrent or persistent in nature
• Appropriate clinical studies/tests including cephalometric tracings and analysis addressing the physical and/or physiological abnormality that confirm its presence and the degree to which it is causing impairment, with appropriate measurements, when applicable Radiologic film interpretations including lateral cephalometric radiograph, AP radiograph and panoramic radiograph
• Clinical photographs of the member's occlusion Diagnostic Polysomnography for obstructive sleep apnea surgery
• Treating physician's plan of care including surgical treatment objectives, which must include the expected outcome for the improvement of the functional deficit
• History of previous non-surgical and surgical treatment (e.g., with obstructive sleep apnea)

DEFINITIONS

Congenital Defect (CA Only): A condition present at birth.

Cosmetic Services and Surgery (CA only): Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance.

Cosmetic Services and Surgery (WA, OR, TX, and OK only): Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance, as influenced by that Member's underlying psychological makeup or psychiatric condition.

Functional or Physical Impairment: Physical or Functional or Physiological Impairment causes deviation from the normal function of a tissue or organ. These 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.

Obstructive Sleep Apnea: The American Academy of Sleep Medicine (AASM) defines Obstructive Sleep Apnea as a sleep related breathing disorder that involves a decrease or complete halt in airflow despite an ongoing effort to breathe.

OSA severity is defined as:
- Mild for AHI or RDI ≥ 5 and < 15
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30/hr

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.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Reconstructive Surgery (CA Only): Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include a cleft palate, cleft lip, or other craniofacial anomalies related with a cleft palate. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.

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 guideline 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 and Guidelines may apply.

Note: The following codes are excluded from coverage. However, there are exceptions to the exclusion that require review. 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

CPT Code	Description
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
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 grafts (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)

CDT Code	Description
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
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 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

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.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description

07/01/2019	**Template Update**
	• Added *Documentation Requirements* section
	Coverage Rationale
	• Revised coverage rationale:
	  ○ Simplified content
	  ○ Replaced language indicating "[the listed services] *are* eligible for coverage as reconstructive and medically necessary" with "[the listed services] *may be* eligible for coverage as reconstructive and medically necessary"
	  ○ Modified list of services that may be eligible for coverage as reconstructive and medically necessary; removed:
	  ▪ Post-Surgical Sequela
	  ▪ Cleft lip/palate (for cleft lip/palate related Jaw Surgery)
	  ○ Modified list of coverage limitations and exclusions; removed:
	  ▪ Surgery for torus mandibularis and torus palatinus for fabrication of dentures
	  ○ Removed language indicating some states may require orthognathic (jaw) surgery for cleft lip and cleft palate, or for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment
	Definitions
	• Updated definitions:
	  ○ Added definition of "Obstructive Sleep Apnea"
	  ○ Removed definition of:
	  ▪ Cancer Sequela
	  ▪ Post-Surgical Sequela
	Supporting Information
	• Updated definition of "Reconstructive Surgery (CA Only)"
	• Archived previous policy version MMG09.K

INSTRUCTIONS FOR USE

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare West Medical Management 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.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.