TITLE: ORTHOGNATHIC SURGERY

EFFECTIVE DATE: September 09, 2019

This policy was developed with input from specialists in Oral and Maxillofacial Surgery and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless these programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member’s case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica UM policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing criteria that generally determine the medical necessity of orthognathic surgery. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

I. Definitions

A. Apnea-Hypopnea Index (AHI): Calculated as the number of episodes of apnea plus hypopnea per hour of sleep.

B. Cancer Sequela: A pathological condition resulting from a cancer, e.g., destruction of bone in the jaw from radiation therapy.

C. Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth. For example, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome.

D. Cosmetic Procedure: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Medica.

E. Function/Physical Impairment: A physical/functional or physiological impairment causes deviation from the normal function of a tissue or organ. This result 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.

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

G. 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.

H. Post-Surgical Sequela: A pathological condition resulting from surgery to the jaw, e.g., slippage of hardware used to stabilize a fractured jaw.

I. Respiratory Disturbance Index (RDI): The number of apneas, hypopneas and respiratory effort-related arousal (RERA) per hour of sleep, confirmed by EEG.
J. **Reconstructive Procedures**: Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

1. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

2. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

**BENEFIT CONSIDERATIONS**

1. Prior authorization **is required** for orthognathic surgery. Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member’s plan document.
3. Cosmetic surgery is excluded in the member’s coverage document.
4. Medical director review is required for any of the following maxillofacial surgeries when it is performed in conjunction with uvulopalatopharyngoplasty. Please refer to Medica’s utilization management policy, *Uvulopalatopharyngoplasty (UPPP or U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome (III-SUR.08)*.
   A. Inferior mandibular sagittal osteotomy
   B. Geniohyoid advancement
   C. Bimaxillary advancement
   D. Genioglossus advancement
5. Some states may require coverage for orthognathic (jaw) surgery for cleft lip and cleft palate such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to the member specific benefit plan document.
6. Medical Director review and/or oral surgery consultation is required for all cases where the member is 18 years of age or less and may be requested at the discretion of the reviewer prior to coverage determination for members over 18 years of age.
7. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's plan document.
8. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeal process in their Medica Provider Administrative Manual.

**MEDICAL NECESSITY CRITERIA**

All orthognathic (jaw) surgeries are subject to some level of review.

1. Orthognathic (jaw) surgery is considered medically necessary when documentation in the medical record indicates that both the skeletal deformation **AND** the functional impairment criteria below are met:
   A. The presence of **one or more of the following** facial skeletal deformities associated with masticatory malocclusion:
      1. Anteroposterior Discrepancies, **one or more of the following** criteria are met:
         a. Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm)
         b. Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm)
         c. These values represent two or more standard deviation from published norms
      2. Vertical Discrepancies
         Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks and **one or more of the following** criteria are met:
a. Open bite:
   i. No vertical overlap of anterior teeth
   ii. Unilateral or bilateral posterior open bite greater than 2 mm
b. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
c. Supraeruption of a dentoalveolar segment due to lack of occlusion

3. Transverse Discrepancies, **one or more of the following** criteria are met:
   a. Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms
   b. 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

4. Asymmetries, **one or more of the following** criteria are met:
   a. Anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry

B. In addition to meeting the skeletal deformity requirement above, the patient must also have **one or more of the following** functional impairments:
   1. 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)
   2. Speech deficits supporting existence of speech impairment due to skeletal malocclusion
   3. Moderate to severe obstructive sleep apnea when all of the following are met:
      a. Polysomnography reflects AHI or RDI greater than or equal to 15 per hour
      b. Documented oropharyngeal narrowing secondary to maxillomandibular deficiency is the primary cause of obstructive sleep apnea

II. For Obstructive Sleep Apnea
   A. Maxillomandibular advancement surgery (MMA):
      1. For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 23rd edition, 2019, Maxillomandibular Osteotomy and Advancement, A-0248 (ACG).
   B. Multilevel procedures whether done in a single surgery or phased multiple surgeries:
      1. There are a variety of procedure combinations, including mandibular osteotomy and genioglossal advancement with hyoid myotomy (GAHM). For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 23rd edition, 2019, Mandibular Osteotomy, A-0247 (ACG).

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**DOCUMENT HISTORY**

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<thead>
<tr>
<th>Original Effective Date</th>
<th>June 2010</th>
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<tbody>
<tr>
<td>MPC Endorsement Date(s)</td>
<td>06/2010, 06/2011, 06/2012, 06/2013, 09/2014, 10/2017, 11/2018</td>
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<tr>
<td>Began use of MCG™ Care Guidelines (Note: Beginning 01/01/2018, both Medica &amp; MCG criteria are used in combination)</td>
<td>02/2016 (19th Edition)</td>
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<tr>
<td>Administrative Update(s)</td>
<td>05/01/2017</td>
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**References**

**10/2017 MPC:**


11/2018 MPC:
No new references added.