n05630

Orthognathic Surgery

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) Utilization Management (UM) department, applies review guidelines for determinations involving medical necessity for when it is appropriate to utilize orthognathic surgery services. This policy provides guidance for approving these procedures for NHP/NHIC/NHAS. Orthognathic surgery may be contractually excluded for some plans. Please refer to the individual's coverage document for details. The coverage document takes precedence over clinical policy and must be considered first in determining coverage eligibility.

Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, or Individual and Family Plan to determine eligibility and coverage because Employer Group/Plan Sponsor and government contracts may vary. NHIC follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership.

Procedure Detail:

I. Description
   A. Orthognathic surgery is the surgical correction of abnormalities of the mandible, maxilla, or both. The underlying abnormality may be congenital (present from birth), may become evident as an individual grows and develops, or may be the result of a traumatic injury. These deformities contribute to significant masticatory dysfunction and/or functional impairments. In addition, the severity of these deformities does not allow adequate treatment from dental and/or orthodontic treatment alone. Decisions regarding the most appropriate care is complex and judgment should be made by considering each individuals' clinical situation and medical history. This policy defines the medical necessity indications that Network Health will follow to approve or deny orthognathic surgical procedures for individuals with documented significant physical functional impairment.

II. Medical Indications/Criteria
   A. Network Health considers orthognathic surgery medically necessary to correct skeletal deformities of the maxilla and/or mandible when **ALL** the following are present:

1. Maxillary and/or mandibular facial skeletal deformities associated with accidental injury related to trauma involving the oral cavity and requiring surgical treatment **OR** congenital deformity (a condition present at birth needing to be addressed at the time of birth or up to one (1) year after birth); **and**
2. The patient is experiencing **ANY ONE (1)** of the following functional impairments:
    a. Persistent difficulties with chewing and swallowing (neurological and metabolic reasons must be ruled out) that have been evaluated by a speech language pathologist/therapist; **OR**
    b. Malnutrition, failure to thrive and/or significant weight loss noted secondary to the congenital facial deformity (weights/nutrition deficiencies must be addressed by a medical professional and documented in the medical record); **OR**
    c. Speech dysfunction directly related to the jaw deformity as determined by a speech and language pathologist or therapist; **OR**
    d. Pain secondary to the facial skeletal deformity that has persisted for at least a year, despite conservative treatment (including but not limited to splint, NSAIDS, and physical therapy).

B. Network Health considers orthognathic surgery not medically necessary for:
1. Impairments related to the production of speech involving muscular coordination.
2. Cosmetic correction for unaesthetic facial features:
    a. Network Health considers orthognathic surgery for the correction of unaesthetic facial features (regardless of association with a psychological disorder) cosmetic and not medically necessary.

III. Coverage
A. NHP/NHIC/NHAS may extend coverage for orthognathic surgery procedures as medically necessary for the indications as noted in this policy.
B. NHIC follows CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for application to its Medicare Advantage membership.

IV. Limitations/Exclusions
A. Network Health considers orthognathic surgery not medically necessary for the diagnoses noted above when the criteria as described are not met.
B. Expenses associated with orthodontic treatment phases of care, including pre- and/or post-surgical, are considered dental in nature and not covered under the medical plans offered by Network Health.
C. Orthognathic surgery may be contractually excluded. Please refer to the individual's coverage document for details. The coverage document takes precedence over clinical policy and must be considered first in determining coverage eligibility.
D. Orthognathic surgery (i.e. Le Fort) is considered E/I for the treatment of Temporomandibular joint (TMJ) conditions.

V. References
A. "What Medicare Doesn't Cover" section under the Medicare Dental Coverage overview at https://www.cms.gov/medicare/coverage/dental
B. Jung H-D, Kim S Y, Park H-S, Jung Y-S Orthognathic surgery and temporomandibular joint symptoms Jung et al. Maxillofacial Plastic and Reconstructive Surgery (2015) Dec; 37(1):14 DOI 10.1186/s40902-015- 0014-4
C. Verhelst, Pieter-Jan & Van der Cruyssen, Frederic & Laat, Antoon & Jacobs, Reinhilde & Politis, Constantinus. (2019). The Biomechanical Effect of the

Sagittal Split Ramus Osteotomy on the Temporomandibular Joint: Current Perspectives on the Remodeling Spectrum. Frontiers in Physiology. 10. 10.3389/fphys.2019.01021.

D. Medicare Benefit Policy Manual (Pub 100-2), Ch 15, Covered Medical and Other Health Services, Section 150-Dental Services; @ http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

E. Medicare Benefit Policy Manual Chapter 16 General Exclusions from Coverage, Section 140 – Dental Services Exclusion @ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf

CPT Codes

21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedgeexcision 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 inany 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 movementin any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement inany 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 movementin 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)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant, par
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
*CPT codes are subject to change as codes are retired or new ones developed.	

Regulatory Citations:
UM 2

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

Origination Date: 05/01/2018	**Approval Date:** 04/18/2024	**Next Review Date:** 04/18/2025
Regulatory Body: NCQA	**Approving Committee:** Medical Policy Committee	**Policy Entity:** NHAS,NHIC,NHP
Policy Owner: Rachell Hall	**Department of Ownership:** Utilization Management	**Revision Number:** 7
Revision Reason: 05/01/2018- new policy developed 05/16/2019- annual review 04/16/2020-annual review 04/15/2021-annual review, minor grammar and formatting updates, removed clinical indications that spoke to malocclusion, added CPT codes 04/21/2022 - annual review, minor grammar updates, references updated (Medical Policy Committee approved 4/21/22) Approved by Medical Policy Committee on 04/21/2022 06/15/2023-annual review, clarification made:articulation removed and replaced with production of speech involving muscular coordination, minor grammar updated, references updated. Approved at Medical Policy Committee on 06/15/2023. 4/18/24- annual review, minor grammar updates, references updated, CPT/HCPCS codes reviewed.		

NETWORK HEALTH PLAN/NETWORK HEALTH INSURANCE CORPORATION
MEDICAL POLICY DEVELOPMENT/REVIEW SUMMARY

1570 Midway Pl.
Menasha, WI 54952

Meeting: Utilization Management Committee	Date: 4/18/2024
Title/Topic: Medical Policy – Orthognathic Surgery	Policy Number: n05630
Purpose: Annual Review	Outcome: Accept with changes as outlined
Line of Business: Commercial and Medicare	Effective Date: 4/18/2024

INTRODUCTION:
Includes definition of problem or opportunity. Provides background information on the topic. Describes current state. May also include prior state and/or factors that have changed. Includes operational definitions where key terms may have varied interpretation.

Orthognathic surgery is the surgical correction of abnormalities of the mandible, maxilla, or both. The underlying abnormality may be congenital (present from birth), may become evident as an individual grows and develops, or may be the result of a traumatic injury. These deformities contribute to significant masticatory dysfunction and/or functional impairments. The severity of these deformities does not allow adequate treatment from dental and/or orthodontic treatment alone. Decisions regarding the most appropriate care is complex and judgment should be made by considering everyone's clinical situation and medical history.

Orthognathic surgery may be contractually excluded for some plans. The UM coordinator is to refer to the individual's coverage document for details. The coverage document takes precedence over clinical policy and must be considered first in determining coverage eligibility.

This medical policy provides guidance for Utilization Management Coordinator Registered Nurses (UMC-RN) regarding determinations involving the medical necessity for orthognathic surgery for individuals with documented significant physical functional impairment of the jaw. This policy is due for annual review.

ACTION RECOMMENDED:
States recommendations in specific terms. Includes a summary of what should be accomplished, methods, and timetable (if applicable). Recommendations on implementation and follow-up plans may also be included.

Annual review has been conducted and the Orthognathic Surgery medical policy is presented for review and approval as written.

No changes were made to the intention or utilization guidance of this policy. Annual review was performed, a review and update of references was conducted, minor grammar changes were made, and CPT/HCPCS code verification was performed.

ANALYSIS/JUSTIFICATION:
Includes information relevant to the recommended action including information used in formulation the recommendations. Information will include reference to any existing Centers for Medicare & Medicaid Services (CMS) coverage determinations as well as any existing established vendor criteria. Information may include financial/cost data, service measures, projections or other key measures or process tools, recommendations from a clinical provider with expertise regarding the topic, and/or information from other widely used treatment guidelines or peer reviewed clinical literature.

MCG does not have specific criteria available for these requests. MCG does have guidelines and treatment guidance surrounding orthognathic surgery for the treatment of sleep apnea.

Centers for Medicare & Medicaid Services (CMS) does not have a pertinent National Coverage Determination (NCD) or Local Coverage Determination (LCD).

This medical policy was developed to provide guidance for orthognathic surgical procedures for individuals with documented significant physical functional impairments of the jaw.

REFERENCES:
Includes detailed description regarding source(s) of information used for development of policy or recommendations via citation.

- "What Medicare Doesn't Cover" section under the Medicare Dental Coverage overview at https://www.cms.gove/medicare/coverage/dental
- Jung H-D, Kim S Y, Park H-S, Jung Y-S Orthognathic surgery and temporomandibular joint symptoms Jung et al. Maxillofacial Plastic and Reconstructive Surgery (2015) Dec; 37(1):14 DOI 10.1186/s40902-015- 0014-4
- Verhelst, Pieter-Jan & Van der Cruyssen, Frederic & Laat, Antoon & Jacobs, Reinhilde & Politis, Constantinus. (2019). The Biomechanical Effect of the Sagittal Split Ramus Osteotomy on the Temporomandibular Joint: Current Perspectives on the Remodeling Spectrum. Frontiers in Physiology. 10. 10.3389/fphys.2019.01021.
- Medicare Benefit Policy Manual (Pub 100-2), Ch 15, Covered Medical and Other Health Services, Section 150-Dental Services; @ http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf
- Medicare Benefit Policy Manual Chapter 16 General Exclusions from Coverage, Section 140 – Dental Services Exclusion @ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf

REVISION REASION:
Includes the date changes or updates were made and summary of changes applied.

4/18/2024- Annual review was completed. Minor grammar changes were made. References were reviewed and updated. A CPT/HCPCS code review was conducted without changes made.

Disclaimer:
Contract language as well as state and federal laws take precedence over any medical policy.

Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.