Medical Coverage Policy | Orthognathic Surgery

EFFECTIVE DATE: 05|10|2006
POLICY LAST UPDATED: 12|17|2013

OVERVIEW

Orthognathic surgery refers to the surgical correction of abnormalities of the maxilla, mandible or both.

PRIOR AUTHORIZATION

Commercial Products:
Prior Authorization is recommended for Commercial Products.

POLICY STATEMENT

BlueCHiP for Medicare

Orthognathic surgery is **not covered for BlueCHiP for Medicare** members.

Commercial Products:

Orthognathic surgery is considered **medically necessary** when the severity of the skeletal deformity results in significant functional impairment and the deformity cannot be adequately treated through dental or orthodontic services alone when **any** of the below medical criteria are present.

An orthognathic case involves essentially four phases:

Phase 1:Pre-operative (Noncovered*****)

This is a monitoring and work-up phase which can last 1-3 years depending on the complexity of the case. The oral surgeon is monitoring the patient during orthodontic treatment/growth to determine the correct timing for the surgery.

Phase 2:Pre-operative Records/Stabilization (Noncovered*****)

As the date for surgery gets closer, the surgeon must perform model surgery, tracings of the pre and post-op results and fabrication of the fixation devices which will stay in the patient's mouth for approximately 6-8 weeks after surgery. This is all accomplished outside of patient office visits.

Phase 3:Surgery (Covered with prior authorization)

The surgical procedure of jaw movement and fixation in the hospital setting is performed. The patient usually has a 3-5 day hospital stay. A 90-day post-operative period is included in this fee.

Phase 4:Post-op After 90 Days (Noncovered*****)

The Oral Surgeon continues to monitor the patient for a period of 1-3 years following the surgical phase.

Under BCBSRI policy, the surgery (phase 3) with preauthorization is a covered benefit and reimbursed by Blue Cross medical coverage.

*****The pre-operative phase (phase 1), pre-operative records/stabilization (phase 2), and post-op after 90-days (phase 4) are not covered benefits under the member's medical or BCBSRI dental plan. The services performed in phases 1, 2, and 4 are member responsibility. The fee for phases 1, 2, and 4 is determined by the oral surgeon prior to surgery and is dependant on the complexity of the case. It is the surgeon's responsibility to discuss the fee with the patient prior to surgery.

The following are considered a **contract exclusion** when performed in conjunction with orthognathic surgery for the sole purpose of improving patient appearance:

- Rhinoplasty for nose reshaping
- Osteoplasty for facial bone reductions for cosmetic reasons
- Genioplasty to improve the appearance of the chin
- Rhytidectomy (face-lift

MEDICAL CRITERIA

Orthognathic surgery is considered **medically necessary for all product lines EXCEPT BlueCHiP for Medicare** when **any** of the following facial skeletal deformities are present.

1. **Anteroposterior discrepancies**:
    - Maxillary/mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm); **or**
    - Maxillary/mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm). (These values represent two or more standard deviations from published norms*).
2. **Vertical discrepancies**:
    - Presence of a vertical facial skeletal deformity that is two or more standard deviations from published norms for accepted skeletal landmarks; **or**
    - Open bite:
        - No vertical overlap of anterior teeth; **or**
        - 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; **or**
    - Supraeruption of a dentoalveolar segment due to lack of occlusion.
3. **Transverse discrepancies**:
    - Presence of a transverse skeletal discrepancy that is two or more standard deviations from published norms; **or**
    - 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.
4. **Asymmetries**:
    - Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry

* "Published norms" available from *Surgical Correction of Dentofacial Deformities* by Epker, Fish & Stella and *Contemporary Treatment of Dentofacial Deformity* by Proffit, Sarver & White.

Required Documentation:
The following clinical documentation is required to determine medical necessity for orthognathic surgery:

- Study models (bite-wax registration)
- Photos for both frontal and profile smiling
- Presurgical frontal and lateral cephalograms
- Panoramic film
- Consultation letter (diagnostic/treatment plan)
- Prediction tracing using presurgical cephalogram

The required documentation (study models, photos, cephalogram, panoramic film, consultation letter, prediction tracing) must be completed within six (6) months of submitting the case for review..

BACKGROUND

Orthognathic surgery refers to the surgical correction of abnormalities of the maxilla, mandible or both. The underlying abnormality may be present at birth or may become evident as the patient grows and develops or may be the result of traumatic injuries, systemic conditions or environmental influences. Surgery is generally performed when the severity of the skeletal deformity results in significant functional impairment and the deformity cannot be adequately treated through dental or orthodontic services alone. Examples of conditions that could require orthognathic surgery are mandibular prognathism, crossbite, open bite, overbite, underbite, mandibular deformity, and maxillary deformity. The goal of treatment is to improve function through correction of the underlying dentoskeletal deformity.

Correcting this dentoskeletal deformity through orthognathic surgery requires comprehensive preoperative planning and coordination with other dentists and dental specialists. An oral and maxillofacial surgeon or plastic and reconstructive surgeon performs the surgery itself. Due to its complexity, precision and duration it often requires two surgeons. The surgery involves cutting the maxilla (upper jaw) or mandible (lower jaw) or both. The bones are then realigned to achieve goals such as normalized occlusion, relief of pain, improved chewing, swallowing and speech.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) believe orthognathic surgery is supported by clinical evidence for specific conditions. These include the treatment of maxillary and/or mandibular facial skeletal deformities associated with masticatory maloccusion such as specific anteroposterior, vertical transverse discrepancies and asymmetries.

Orthognathic surgery in the absence of significant physical functional impairment is considered cosmetic and **not medically necessary**

Augmentation, such as implants, to reshape or enhance parts of the face is considered **not medically necessary** when performed in conjunction with orthognathic surgery for the sole purpose of improving patient appearance.

COVERAGE

Commerical Products:

Benefits may vary between groups and/or contracts. Please refer to the appropriate evidence of coverage, subscriber agreement, or member certificate for the applicable surgery benefits/coverage.

CODING

Commerical Products:

Cosurgery for the primary procedure should be reported utilizing the -62 modifier.

RELATED POLICIES

None

PUBLISHED

Provider Update	Feb 2014
Provider Update	Mar 2012
Provider Update	Feb 2009
Provider Update	Oct 2007

REFERENCES

1. Lucille Packard Children's Hospital at Stanford: Craniofacial Anomalies: Orthognathic (Maxillofacial) Facial Surgery:http://www.lpch.org/DiseaseHealthInfo/HealthLibrary/craniofacial/maxface.html

2. American Association of Oral and Maxillofacial Surgeons: *Coding for Orthognathic Surgery.* Retrieved on 4/16/2007 from http://www.aaoms.org/docs/practice_mgmt/coding_papers/orthognathic_surgery.pdf

3. J Oral Maxillofacial Surg. 2003 Jun; 61 (6): 655-61. Wolford, LM, Reiche-Fischel O., Mehra P. Changes in temporomandibular joint dysfunction after orthognathic surgery. Retrieved on 4/30/2007 from

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