NO. 91273-R10

ORTHOGNATHIC SURGERY

Effective date: 12/01/2025 **Last reviewed**: 11/2025

Instruction for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Related policies:

- No. 91353 Temporomandibular Joint Disorders (TMJD)

I. MEDICAL NECESSITY CRITERIA

A. Orthognathic surgery is medically necessary when performed to correct functional impairment. Functional impairment is defined as a decrease or lack of normal action or function of a body part due to congenital or developmental defect, pain, illness, or injury that prevents or interferes with activities of daily living. The following orthognathic related procedures are considered medically necessary when the corresponding InterQual® criteria are met:

- Maxillectomy
- Osteotomy, Anterior Segment, Mandible
- Osteotomy, Anterior Segment, Maxilla
- Osteotomy, LeFort I
- Osteotomy, Maxillary Buttress, +/- Mid Palatal Osteotomy
- Osteotomy, Sagittal Split, Mandible Ramus Maxillectomy

Note: The above procedures are addressed within the following InterQual CP:Procedures subsets:

Orthognathic Surgery

Orthognathic Surgery (Pediatric)

B. Orthognathic surgery for cosmetic/aesthetic or dental reasons is considered not medically necessary.

C. Documentation must be available for retrospective review upon request.

D. Dental services (e.g. x-rays, bite splint, orthodontia) provided either before or after surgery are not a covered benefit.

E. If the treatment is determined to be medically/clinically necessary, only the following services will be included:

1. Referral care for evaluation and treatment
2. Cephalometric x-rays
3. Surgery and post-operative care, including post-operative radiographs
4. Surgical facility/hospital

F. **Michigan Medicaid**: Children's Special Health Care Services (CSHCS) enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid. Examples of enhanced dental services may include orthodontics, dental implants, and augmented crown and bridge services beyond Medicaid's limited crown coverage. One example of a CSHCS diagnosis that may qualify for enhanced dental services is: *Severe maxillofacial or craniofacial anomalies that require surgical intervention, including* ***orthognathic surgery****.*

Refer to the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual for current information:

Children's Special Health Care Services

Benefits

CSHCS Enhanced Dental Services

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the

Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified.	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	None identified.
First Coast Service Options, Inc.	None identified.
National Government Services, Inc.	None identified.
Noridian Healthcare Solutions	None identified.
Novitas Solutions, Inc.	None identified.
Palmetto GBA	Cosmetic and Reconstructive Surgery L33428 A56658
WPS Insurance Corporation	None identified.

III. BACKGROUND

Orthognathic surgery is the surgical correction of skeletal abnormalities of the mandible, maxilla or both. The underlying abnormality may be congenital (intrinsic), present at birth. These abnormalities may be recognized at birth or may not become obvious until the individual grows and develops. The dysmorphology may be extrinsic, the result of traumatic injuries or secondary to systemic diseases. Often, the severity of these deformities necessitates surgical correction in combination with other rehabilitative services, including no surgical therapies.

The primary goal of treatment is to improve form and function through correction of the underlying skeletal deformity.

As a direct effect of the resultant skeletal movements, changes in the soft-tissue drape overlying the facial skeleton may be realized. The soft-tissue changes are

inherent to the procedure and must be considered in the surgical work-up and are not considered the primary goal of surgery.

Malocclusion is a misalignment between the upper teeth and the lower teeth when the jaw is closed. The Angle classification of malocclusion is used to identify the type of malocclusion. Class I describes a normal or near normal relationship between the upper and lower teeth. Class II is also called overbite and describes the top teeth abnormally overlapping and jutting out from the bottom teeth. A class II malocclusion is present if the bite space between the upper and lower teeth is over 2 mm. Class III is also called underbite or crossbite and describes the protrusion of the bottom teeth abnormally overlapping the top teeth.

Maxillofacial deformities include bony defects in the upper (maxilla) and lower (mandible) jaw, as well as the associated soft tissue. The management of these deformities can include surgery, imaging, orthodontics, prosthodontics, speech therapy, sleep medicine evaluation, and psychiatric evaluation. The American Association of Oral and

Maxillofacial Surgeons lists general indications for medically necessary maxillofacial surgery that include malocclusion, speech pathology, dental pathology, social or psychological impairment from skeletal deformities, chewing and swallowing abnormalities, temporomandibular joint disorders, or sleep disordered breathing.

An osteotomy is cutting through the bone and repositioning it to transfer load or weight bearing from the pathologic to the normal joint alignment.

Gathering data via physical examination and imaging provides the information needed to determine the need for this procedure. According to the American Association of Oral and Maxillofacial Surgeons, a presurgical evaluation for orthognathic surgery includes panoramic photographs, cephalometric analysis, dental model assessment, and facial photographs.

Genioplasty is a procedure to reshape or reposition the chin. Guidelines from the American Association of Oral and Maxillofacial Surgeons state that chin advancement and genial advancement (types of genioplasty) can be necessary as adjunctive procedures for treatment of obstructive sleep apnea (OSA) and that genioplasty can be considered as a supplemental procedure (when combined with other primary orthognathic procedures) for correction of a skeletal-facial discrepancy (anteroposterior, transverse, vertical, asymmetry) and the associated functional deficits.

InterQual® Procedures criteria

InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Association of Oral and Maxillofacial Surgeons (AAOMS)	Indications for Orthognathic Surgery (2025) Parameters of Care (2023)

	Surgical Correction of Maxillofacial Skeletal Deformities (2023)
American College of Radiology	ACR Appropriateness Criteria® Sinonasal Disease: 2021 Update (May 2022)
National Comprehensive Cancer Network (NCCN)	Clinical practice guidelines in oncology, head and neck cancers

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

VI. CODING

Services billed with the following diagnoses are subject to limitations of the orthognathic benefit.

ICD-10 Codes that apply to this policy:

M26.00 Unspecified anomaly of jaw size
M26.01 Maxillary hyperplasia
M26.02 Maxillary hypoplasia
M26.03 Mandibular hyperplasia
M26.04 Mandibular hypoplasia
M26.05 Macrogenia
M26.06 Microgenia
M26.07 Excessive tuberosity of jaw
M26.09 Other specified anomalies of jaw size
M26.10 Unspecified anomaly of jaw-cranial base relationship
M26.11 Maxillary asymmetry
M26.12 Other jaw asymmetry
M26.19 Other specified anomalies of jaw-cranial base relationship

M26.50 Dentofacial functional abnormalities, unspecified
M26.51 Abnormal jaw closure
M26.52 Limited mandibular range of motion
M26.53 Deviation in opening and closing of the mandible
M26.54 Insufficient anterior guidance
M26.55 Centric occlusion maximum intercuspation discrepancy
M26.56 Non-working side interference
M26.57 Lack of posterior occlusal support
M26.59 Other dentofacial functional abnormalities

Procedures:
Professional and facility services subject to Orthognathic benefit include:
Anesthesia Services
Injection and Injectable medications
Imaging & Radiology
Physician Services
Surgery & Reconstructive Surgery, including but not limited to:
21085 Impression and custom preparation; oral surgical splint

21121 Genioplasty; sliding osteotomy, single piece
21122 Genioplasty; sliding osteotomies, two or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
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; two pieces, segment movement in any direction, without bone graft
21143 Reconstruction midface, LeFort I; three 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; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147 Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
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)
21208 Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

21209 Osteoplasty, facial bones; reduction
21210 Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215 Graft, bone; mandible (includes obtaining graft)

21299 Unlisted craniofacial and maxillofacial procedure
41899 Unlisted procedure, dentoalveolar structures

If the above surgical procedures are billed for other diagnosis, prior authorization will be required.

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

1. Expert Panel on Neurological Imaging; Hagiwara M, Policeni B, Juliano AF, Agarwal M, Burns J, Dubey P, Friedman ER, Gule-Monroe MK, Jain V, Lam K, Patino M, Rath TJ,

Shian B, Subramaniam RM, Taheri MR, Zander D, Corey AS. ACR Appropriateness Criteria® Sinonasal Disease: 2021 Update. J Am Coll Radiol. 2022 May;19(5S):S175-S193. doi: 10.1016/j.jacr.2022.02.011. PMID: 35550800.
2. Gateno J, Alfi D, Xia JJ, Teichgraeber JF. A Geometric Classification of Jaw Deformities. J Oral Maxillofac Surg. 2015 Dec;73(12 Suppl):S26-31. doi: 10.1016/j.joms.2015.05.019. PMID: 26608152; PMCID: PMC4666701.
3. Parameters of Care. J Oral Maxillofac Surg. 2023 Nov;81(11S):E2-E12. doi: 10.1016/j.joms.2023.06.023. PMID: 37833024.
4. Surgical Correction of Maxillofacial Skeletal Deformities. J Oral Maxillofac Surg. 2023 Nov;81(11S):E95-E119. doi: 10.1016/j.joms.2023.06.026. PMID: 37833031.

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