Priority Health

MEDICAL POLICY
No. 91273-R9

ORTHOGNATHIC SURGERY

Effective Date: December 1, 2024	**Review Dates: 1/93, 7/95, 10/97, 4/99, 10/00, 8/01, 12/01, 4/02, 2/03, 1/04, 1/05, 12/05, 12/06, 12/07, 12/08, 12/09, 12/10, 12/11, 12/12, 12/13, 11/14, 11/15, 11/16, 11/17, 11/18, 11/19, 11/20, 11/21, 11/22, 11/23, 11/24**
Date Of Origin: November 15, 1988	**Status: Current**

Summary of Changes

Deletions:

- References to "benefit" or "covered" or "co-payment" were removed to avoid inaccuracies and inconsistencies with member benefit documents and certificates of coverage.

I. POLICY/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

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

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, 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, please refer to the Priority Health Provider Manual.

III. APPLICATION TO PRODUCTS

Coverage is subject to 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) and/or the Evidence of Coverage (EOC); 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 located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

Special Notes: *See Temporomandibular Joint Disorders (TMJD) Policy*
See Certificate of Coverage

IV. DESCRIPTION

Orthognathic surgery is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction.

V. CODING INFORMATION

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.

VI. REFERENCES

1. Orthognathic Surgery. Medical Coverage Policy 0209. Cigna. Effective date October 15, 2023.
2. Orthognathic Surgery Guidelines. Michigan Association of Health Plans (MAHP). 2019.