

Medical Policy



Orthognathic Surgery

Policy Number: PG0226
Last Review: 11/01/2024

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

☒ Professional
☐ Facility

DESCRIPTION:

Orthognathic surgery is the surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw), maxilla (upper jaw), facial skeleton, and associated soft tissues. These abnormalities may be caused by genetic, environmental, developmental, functional and/or pathologic anomaly apparent at birth or manifested in subsequent growth and development or acquired through trauma, neoplastic processes, and degenerative diseases. These surgical procedures involve manipulation of the facial skeleton, particularly the maxilla and mandible, to restore the proper anatomic and functional relationship in individuals with dentofacial skeletal anomalies. These procedures include osteotomy, ostectomy, or osteoplasty, and the insertion of plates, screws, and wires to hold bones together. Several surgical methods may be used depending on the severity of the deformity.

Congenital or developmental defects can interfere with the normal development of the face and jaws. These birth defects may interfere with the ability to chew properly and may also affect speech and swallowing. In addition, trauma to the face and jaws may create skeletal deformities that cause significant functional impairment. Functional deficits addressed by this type of surgery are those that affect the skeletal masticatory apparatus such that chewing, speaking and/or swallowing are impaired.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

- Orthognathic surgery (21120-21123, 21125, 21127, 21141-21143, 21145-21147, 21150, 21151, 21154, 21155, 21159, 21160, 21181-21184, 21188, 21193-21196, 21198, 21199, 21206, 21208-21210, 21215, 21230, 21240, 21244-21249, 21255, 21270, 21275, 21295, 21296) requires prior authorization.
- Procedure code 21235 does not require a prior authorization.

REVIEW SPECIFICS

Procedures performed with the primary purpose of improving physical appearance or to treat psychological symptomatology or psychosocial complaints are cosmetic in nature and not medically necessary. A Medical Director/Associate Medical Director will review medical and dental records (including study models, x-rays, photographs) to determine if the surgery is cosmetic or reconstructive in nature. The review focus is to evaluate the degree of spatial asymmetry and presence of resultant medical problem due to asymmetry. Information may be submitted for evaluation to an oral surgery specialist for final determination.

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TERMS THAT MAY BE USED IN THESE CASES INCLUDE, not all-inclusive:

- Maxillofacial surgery
- Facial plastic surgery
- Mandibular surgery
- Maxillary surgery
- Osteotomy or osteoplasty (bone removal or addition)
- Craniofacial surgery
- Mentoplasty (chin surgery)
- LeForte I, II, or III procedures

COVERAGE CRITERIA

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount covers orthognathic surgery with prior authorization for the following indications:

1. For initial and immediate surgery repair of an abnormal structure of the maxilla and mandible facial skeletal deformities caused by any of the following:
 - a. Accidental injury
 - b. Significant* Congenital (apparent at birth) defect (i.e., cleft palate, Crouzon's syndrome, or Treacher Collins dysostosis)
 - c. Significant* Developmental abnormality
 - d. Disease
 - e. Infection
 - f. Trauma
 - g. Cancerous tumor growth
 - h. Severe or handicapping malocclusion (clinical evidence of speech abnormalities, swallowing difficulties, difficulty chewing, weight loss, malnutrition)
 - i. Severe or handicapping malocclusion is defined as a deformity where the patient has difficulty in swallowing or in the ability to chew only soft food or intake liquids. For these patients, there should be evidence of significant and persistent symptoms and other causes of swallowing and oral problems should have been evaluated. Paramount will require clinical evidence.

*Significant impairment is defined as persistent difficulties with mastication and swallowing as manifested by the inability to incise and/or chew solid foods, choking on incompletely masticated solid foods, and/or damage to soft tissue during mastication.

2. For treatment of speech impairments accompanying severe cleft deformity.
3. Correction of any of the following discrepancies based on tooth position (non-cephalometric) measurements, when it is documented that these skeletal deformities are contributing to significant masticatory dysfunction and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics alone:
 - a. Anteroposterior discrepancies (these values represent two or more standard deviation from published norms [established norm=2mm]) defined as either of the following:
 - i. Maxillary/Mandibular incisor relationship as either of the following:
 1. Horizontal overjet of +5mm or more
 2. Horizontal overjet of zero to a negative value
 - b. Vertical discrepancies defined as any of the following:
 - i. Presence of a vertical facial skeletal deformity, which is two or more standard deviations from published norms for accepted skeletal landmarks.
 - ii. Open Bite as either of the following:
 1. No vertical overlap of anterior teeth

- 2. Unilateral or bilateral posterior open bite greater than 2mm
- iii. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
- iv. Supra-eruption of a dentoalveolar segment due to lack of occlusion from a facial skeletal deformity (does not apply when opposing dentition was removed for other reasons and the teeth have super-erupted)
- c. Transverse discrepancies defined as either of the following:
 - i. Presence of a transverse skeletal discrepancy, which is two or more standard deviations from published norms.
 - ii. Total bilateral maxillary palatal cusp to mandibular central fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.
- d. Asymmetries defined as the following:
 - i. Anteroposterior, transverse, or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry

Computer-assisted technologies, including computerized tomography guided planning procedures and three-dimensional virtual treatment planning, are considered integral to the primary procedure when performed as part of orthognathic surgery.

Orthognathic surgery is considered cosmetic and therefore NOT COVERED in the following instances, not limited to any of the following:

- The procedure is for cosmetic purposes only, improving or altering appearance or self-esteem, including but not limited to psychological or psychosocial symptoms or complaints.
- When no functional impairment is present
- Surgery intended to alter or reshape normal structures of the body in order to improve physical appearance when there is normal human anatomic variation, including by not limited to genioplasty (chin augmentation/implant) performed alone or in conjunction with other orthognathic surgical procedures.
- When there is no change in spatial or functional relationship of the jaws
- To address psychological issues of asymmetry or anatomic variation (appearance)
- For familial chin deformities (“weak chin”)
- For the purposes of improved outcome of orthodontia
- Bone grafting done for the purpose of dental implants, not related to post-traumatic reconstruction or post-surgical (tumor resection) reconstruction.

Orthognathic surgery is considered experimental/investigational and therefore NOT COVERED in the following instances, not limited to any of the following:

- Temporomandibular joint pathology - orthognathic surgery for correction of temporomandibular joint disease or myofascial pain dysfunction
- Condylar positioning devices in orthognathic surgery
- Low-level laser therapy for the management of neurosensory disorders and post-operative edema, pain/paresthesia following orthognathic surgery.
- Manual lymphatic drainage for the management of post-operative edema following orthognathic surgery.
- Three-dimensional virtual treatment planning or computer-aided three-dimensional simulation and navigation in orthognathic surgery (CASNOS)
- Use of Kinesio taping for reduction of swelling in persons after orthognathic surgery

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES

21120	GENIOPLASTY; AUGMENTATION
21121	GENIOPLASTY; SLIDING OSTEOTOMY
21122	GENIOPLASTY; SLIDING OSTEOTOMIES
21123	GENIOPLASTY; SLIDING AUGMENTATION
21125	AUGMENTATION MANDIBULAR BODY; PROSTHETIC MAT
21127	AUGMENTATION MANDIBULAR BODY; W/ BONE GRAFT
21141	LEFORT I RECON; SINGLE PIECE W/OUT BONE GRAFT
21142	LEFORT I RECON; TWO PIECES W/OUT BONE GRAFT
21143	LEFORT I RECON; THREE OR MORE W/OUT BONE GRAFT
21145	LEFORT I RECON; SINGLE PIECE W/ BONE GRAFT
21146	LEFORT I RECON; TWO PIECES W/ BONE GRAFT
21147	LEFORT I RECON; THREE OR MORE W/ BONE GRAFT
21150	LEFORT II RECON; ANTERIOR INTRUSION
21151	LEFORT II RECON; ANY DIRECTION W/ GRAFTS
21154	LEFORT III RECON; W/ BONE GRAFTS W/OUT LEFORT I
21155	LEFORT III RECON; W/ BONE GRAFTS W/ LEFORT I
21159	LEFORT III RECON; W/ FOREHEAD ADV W/OUT LEFORT I
21160	LEFORT III RECON; W/ FOREHEAD ADV W/OUT LEFORT I
21181	RECON BY CONTOURING OF CRANIAL BONES
21182	RECON ORBITAL RIMS/FOREHEAD; W/GRAFTS LESS 40 CM
21183	RECON ORBITAL RIMS/FOREHEAD; W/GRAFTS 40-80 CM
21184	RECON ORBITAL RIMS/FOREHEAD; W/GRAFTS 80 OR MORE
21188	RECON MIDFACE OSTEOTOMIES AND BONE GRAFTS
21193	MANDIBULAR RECONSTRUCTION; W/OUT BONE GRAFT
21194	MANDIBULAR RECONSTRUCTION; W/ BONE GRAFT
21195	MANDIBULAR RECONSTRUCTION; W/OUT INT FIXATION
21196	MANDIBULAR RECONSTRUCTION; W/ INT FIXATION
21198	OSTEOTOMY MANDIBLE; SEGMENTAL
21199	OSTEOTOMY MANDIBLE; W/ ADVANCEMENT
21206	SEGMENTAL OSTEOTOMY
21208	FACIAL OSTEOPLASTY
21209	FACIAL OSTEOPLASTY REDUCTION
21210	NASAL BONE GRAFT
21215	NASAL BONE GRAFT
21230	AUTOGENOUS GRAFT RIB TO FACE
21235	AUTOGENOUS GRAFT EAR TO FACE
21240	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT
21244	RECONSTRUCTION OF MANDIBLE EXTRAORAL
21245	RECONSTRUCTION OF MANDIBLE PARTIAL
21246	RECONSTRUCTION OF MANDIBLE COMPLETE
21247	RECONSTRUCTION OF MANDIBULAR CONDYLE
21248	RECONSTRUCTION OF MANDIBLE W/ IMPLANT PARTIAL
21249	RECONSTRUCTION OF MANDIBLE W/ IMPLANT COMPLETE
21255	RECONSTRUCTION OF ZYGOMATIC ARCH
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL
21275	SECONDARY REVISION OF ORBITALCRANIFACIAL RECON
21295	REDUCTION OF MASSETER MUSCLE/BONE; EXTRAORAL
21296	REDUCTION OF MASSETER MUSCLE/BONE; INTRAORAL

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 03/15/2009

Date	Explanation & Changes
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08/22/2014	<ul style="list-style-type: none"> • Procedure code 21235 will no longer require a prior authorization • Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
05/21/2015	<ul style="list-style-type: none"> • Codes 21137-21139, 21172, 21175, 21179, 21180, 21256, 21260, 21261, 21263, 21267, 21268, 21280, 21282 will be removed from policy • Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
05/27/2016	<ul style="list-style-type: none"> • Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
06/23/2017	<ul style="list-style-type: none"> • Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
12/16/2020	<ul style="list-style-type: none"> • Medical policy placed on the new Paramount Medical Policy Format
02/15/2023	<ul style="list-style-type: none"> • Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
09/01/2023	<ul style="list-style-type: none"> • Medical Policy reviewed and updated to reflect the most current clinical evidence
11/01/2024	<ul style="list-style-type: none"> • Medical Policy reviewed and updated to reflect the most current clinical evidence • Maintain prior authorization required, indicated on the PA/EI/NC spreadsheet, follow InterQual criteria and Medical Policy coverage/noncoverage documentation

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to

<https://www.paramounthealthcare.com/providers/medical-policies/policy-library>

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update>

U.S. Preventive Services Task Force, <https://www.uspreventiveservicestaskforce.org/uspstf/>
Industry Standard Review

Hayes, Inc., <https://www.hayesinc.com/>

Industry Standard Review