BlueCross BlueShield of North Carolina

Medicare Part C Medical Coverage Policy

Orthognathic Surgery

Origination: June 1998
Review Date: February 21, 2024
Next Review: February 2025

****** This policy was implemented in the absence of National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) coverage criteria. This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE OR SERVICE

Orthognathic surgery is a class of surgical procedures designed to realign the maxillofacial skeletal structures with each other and with the other craniofacial structures. This surgery usually involves the maxilla and/or mandible, but other bony components may be involved as well.

Clinical rationale for orthognathic surgery may include the following:

1. Repair of congenital anomalies (cleft lip/palate and other similar anomalies) that produce significant functional impairment (see below)
2. Repair of abnormalities resulting from trauma, tumors or infections that produce significant functional impairment (see below)
3. Treatment of malocclusion that contributes significantly to temporomandibular joint disease (as described in the Plan's policy on treatment of temporomandibular joint disease) and that is not responsive to orthodontic therapy. (There should be documentation to support that the malocclusion is affecting the member's physical health, not just dental health, and the malocclusion has not been amenable to other standard and less invasive forms of treatment.)
4. Treatment of other medical problems (difficulty swallowing, speech abnormalities, malnutrition related to inability to chew, and/or significant intraoral trauma) that produce significant functional impairment, and which have not responded to appropriate therapy and which also have not responded to orthodontic therapy directed at the malocclusion
5. Adjunctive treatment for obstructive sleep apnea (see Medical Coverage Policy: Surgical Treatment of Obstructive Sleep Apnea) following failure of UPPP where obstruction at the hypopharynx and/or tongue base has been documented by direct visual examination by an otolaryngologist.

Orthognathic Surgery is frequently preceded by orthodontics to attempt to correct malocclusion by conservative means or in preparation for surgery. For surgery to be considered under this policy, any preparatory orthodontic therapy must be completed and condition for which surgery is a consideration must still be present, and shown with adequate documentation, after the orthodontic therapy (i.e., the original problem must survive the orthodontics).

POLICY STATEMENT

Coverage will be provided for Orthognathic Surgery when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC. limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC.), the EOC. always governs the determination of benefits.

INDICATIONS FOR COVERAGE

Preauthorization by the Plan is required.

Orthognathic surgery is covered when medically necessary and the symptoms of skeletal facial deformities present a significant functional impairment for the member. The impairment has not been corrected by non-surgical means, including orthodontic therapy when appropriate.

Orthognathic Surgery is covered for each of the following clinical indications when the guidelines listed below are met:

A. Correction of significant congenital (apparent at birth) deformity;

OR

B. Restoration of function following treatment for significant accidental injury, infection or tumor;

OR

C. Treatment of malocclusion that contributes to recalcitrant temporomandibular (TMJ) syndrome symptoms (includes both 1 and 2 below).

1. Signs and/or symptoms are present for at least 4 months. At least one sign and one symptom of TMJ disorder must be present:
    a. Symptoms must include at least one of the following:
        - Painful chewing clearly related to the TMJ **OR**
        - Frequent and significant headaches clearly related to TMJ **OR**
        - Significant and persistent joint and/or muscle tenderness

AND

2. Clinical signs must include at least one of the following**:**
    a. Class III or IV internal derangement of the TMJ **OR**
    b. Restricted range of motion, including at least **one** of the following:
        - Interincisal opening <30 mm **OR**
        - Lateral excursive movement, <4mm **OR**
        - Protrusive excursive movement <4mm **OR**

    c. Significant malocclusion or dental misalignment for patients with one of the following:

- Mandibular excess or maxillary deficiency, a reverse overjet of at least 3mm **OR**
- Mandibular deficiency, an overjet of at least 6mm. (Overjet should be considered/calculated without dental compensation for skeletal abnormality or other skeletal parameters should be considered Wits analysis, ANB, etc.) **OR**
- Open bite of at least 4mm and deep bite of at least 7mm

AND

3. Symptoms are unresponsive to conservative measures for 4 months, including **ALL** of the following:

    - Elimination of aggravating factors (e.g., gum chewing, chewing hard or tough foods) **AND**
    - Use of anti-inflammatory drugs with therapeutic level for at least 6 weeks unless contraindicated **AND**
    - Orthodontic and/or splint therapy (Note: in many cases orthodontic treatment alone cannot correct the abnormality. While orthodontic treatment will be required as part of the overall treatment plan, orthodontic treatment should not be a necessary prerequisite for approval for surgery. Likewise, some members (large open bite patients) cannot tolerate splints as this actually aggravates the problem.

OR

D. Treatment of malocclusion that contributes significantly to **<u>any one</u>** of the following (1, 2, or 3) **<u>and</u>** has failed ≥4 months of non-operative therapy:

1. Speech abnormality
   Must exhibit BOTH of the following:
    - Speech deficit is noticeable to a layperson or primary care physician and significantly impairs the member's ability to communicate.
    - The speech deficit cannot be resolved by speech therapy (requires speech therapy evaluation).

OR

2. Malnutrition related to choking, difficulty swallowing or an inability to masticate that results in:
    - significant weight loss and/or failure to thrive documented in the records over 4 months; **OR**
    - low serum albumin related to malnutrition

OR

3. Significant intraoral trauma while chewing related to malocclusion.
   Information should be supplied which indicates the severity and duration of the trauma and the extent of the interruption to daily activities.

E. Treatment of documented obstructive sleep apnea.

Maxillofacial surgery, including mandibular-maxillary advancement (MMA), may be considered medically necessary in members with mandibular and maxillary deformities contributing to airway dysfunction when there is:

a. Clinically significant OSA (documented by a supervised polysomnography in a sleep laboratory with appropriate monitoring by skilled personnel); **AND**
b. Objective documentation of hypopharyngeal obstruction by physical examination; **AND**
c. Failure of non-surgical treatments, including a good faith effort at treatment with CPAP or BiPAP; **AND**
d. Expectation that orthognathic surgery will decrease airway resistance and improve breathing.

WHEN COVERAGE WILL NOT BE APPROVED

- Orthognathic surgery for cosmetic reasons is not covered.
- Orthognathic surgery for malocclusion when the criteria listed above is not met. The presence of malocclusion alone does not qualify for surgical consideration without demonstrated severe functional impairment.
- Orthognathic surgery where significant risk of recurrence of symptoms or structural abnormalities exist.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes: 21085, 21120, 21121, 21122, 21123, 21125, 21127, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21267, 21268

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

SPECIAL NOTES

Documentation requirements include medical records and photographs, orthodontic measurements and radiological study reports documenting the medical necessity criteria for a given indication.

References:

1. BCBSNC Corporate Medical Policy "Orthognathic Surgery" Effective 10/2014; Accessed via Orthognathic Surgery (bluecrossnc.com) on 01/18/2024.
2. Medicare Local Coverage Article for Oral Maxillofacial Prosthesis – Palmetto GBA Part A/B (L33468); Effective date 10/01/2015. Accessed via LCD - Oral Maxillofacial Prosthesis (L33468) (cms.gov).—retired on 09/17/2017.

Policy Implementation/Update Information:

Revision Date: June 1998; February 18, 2004; February 22, 2006;
February 20, 2008: Added "The presence of malocclusion alone does not qualify for surgical consideration without demonstrated severe functional impairment" to when coverage will not be approved.
September 2009: Code review only
March 2012: No changes to criteria.
January 20, 2015: No changes to criteria. October 29, 2015 updated LCD due to ICD-10 update only.
February 15, 2017; Annual Review, no changes to criteria.

February 20, 2019; Annual Review, No CMS Updates. Minor Revisions Only.
February 17, 2021; Annual Review; No CMS Updates. No Updates to Policy Statement. Minor Revisions Only.
Revision Date: February 15, 2023; Annual Review; No CMS Updates. Minor Revisions only. Added CPT codes 21085 and 21188 under applicable codes as codes are on the prior authorization list.
Revision Date: November 17, 2023: Policy converted to a Summary of Coverage Criteria to align with the 2024 CMS Final Rule.
Revision Date: February 21, 2024: Summary converted back to a policy to align with the 2024 CMS Final Rule. Annual Review. LCD L33738 and LCA A52463 removed from the reference section.

Approval Dates:

Medical Coverage Policy Committee: February 21, 2024

Physician Advisory Group (PAG)/UM Committee: February 20, 2024

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