I. POLICY/CRITERIA

A. Orthognathic surgery is a covered benefit when medically necessary 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 covered according to the following InterQual® criteria:
   - 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 not a covered benefit.

C. Refer to the Summary of Benefits and Coverage (SBC) for member co-payment. The standard co-payment is 50% coverage. This co-payment does not apply for Medicaid or Healthy Michigan Plan members. If the skeletal abnormality requiring orthognathic surgery was manifest at birth and is necessary for restoration of normal functioning in an infant, then the co-payment does not apply. Examples include Pierre Robin Syndrome, Cornelia de Lange Syndrome, Russell Silver Syndrome, and Sotos Syndrome.

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

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

F. If the treatment is determined to be medically/clinically necessary, only the following services will be covered:
   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 Required for Medicaid members only
☒ Retrospective Review (Plan Discretion) for all other products

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); 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
M26.1     Anomalies of jaw-cranial base relationship
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
- Labs
- Office Visits
- 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
AMA CPT Copyright Statement:
All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. 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. 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. 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.

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