

Medicare Advantage Medical Policy



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Orthognathic Surgery – Medicare Advantage

Medicare Advantage Plan

☒ Medicare Plus BlueSM

☒ BCN AdvantageSM

UM Committee Approval Date: 9/17/2025

Effective Date: 10/17/2025

Description

Orthognathic surgery, also known as corrective jaw surgery, is a surgical procedure designed to correct abnormalities in the jaw bones, facial skeleton, and related soft tissues. These abnormalities may result from congenital conditions, developmental issues, or the result from traumatic injuries. The primary goal of orthognathic surgery is to restore optimal alignment and function of the upper and lower jaws, thereby improving biting, chewing, and speaking capabilities. Additionally, this surgery aims to enhance facial aesthetics by achieving a more balanced and harmonious facial structure.

Related Medical Coverage Policies

- Cosmetic and Reconstructive Surgery
- Obstructive Sleep Apnea– Surgical Treatment
- Oral Surgery

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpradmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

Code	Description	CMS Guidance	Additional Guidance
21085	Impression and custom preparation; oral surgical splint	National Coverage Determinations None	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>Orthognathic Surgery</i> To access this policy, please visit the BCBS Michigan Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Local Coverage Determinations and Articles WPS None	
21121	Genioplasty; sliding osteotomy, single piece	CGS None First Coast None	
21122	Genioplasty; sliding osteotomies, two or more osteotomies	NGS None Noridian JE None	
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Noridian JF None Novitas None	
21125	Augmentation, mandibular body or angle; prosthetic material	Palmetto L33428, A56658 – Cosmetic and Reconstructive Surgery A53497 – Oral Maxillofacial Prosthesis	

Code	Description	CMS Guidance	Additional Guidance
21127	Augmentation, mandibular body or angle; with bone graft, onlay, interpositional (includes obtaining autograft)		
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction 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)		
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts)		

Code	Description	CMS Guidance	Additional Guidance
21150	Reconstruction midface, LeFort II; anterior intrusion		
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)		
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I		
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I		
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement requiring bone grafts (includes obtaining autografts); without LeFort I		
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement requiring bone grafts (includes obtaining autografts); with LeFort I		
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)		

Code	Description	CMS Guidance	Additional Guidance
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		
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)		

Code	Description	CMS Guidance	Additional Guidance
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)		
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)		
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)		
21242	Arthroplasty, temporomandibular joint, with allograft		
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement		
21244	Reconstruction of mandible, extraoral, with transosteal bone plate		
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial		
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete		
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts)		
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)		

Code	Description	CMS Guidance	Additional Guidance
21270	Malar augmentation, prosthetic material		
21275	Secondary revision of orbitocraniofacial reconstruction		
21295	Reduction of masseter muscle and bone extraoral approach		
21296	Reduction of masseter muscle and bone intraoral approach		
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide		
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)		

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information 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.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,

Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits;

pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established
10/17/2025	09/17/2025	MA policy foundational language updated. Adoption of JUMP policy updates.