**Title: Orthognathic Surgery**

**Description/Background**

Orthognathic surgery is the surgical correction of skeletal anomalies or malformations involving the jaws, facial skeleton and associated soft tissues. These abnormalities may be caused by genetic, environmental, developmental, functional and/or pathologic aberrations apparent at birth or manifested in subsequent growth and development or acquired through trauma, neoplastic processes and degenerative diseases.

The principal goal of surgical correction of these skeletal deformities in this policy is restoration and/or improvement in function. The surgical procedures considered under this policy involve repositioning the facial bones including the jaw to correct documented functional problems. Generally, the bones are secured in their new positions with plates, screws and/or wires.

Distraction osteogenesis (DO) is a surgical technique for treating maxillofacial deformities in which new bone formation is induced by gradual separation of bony segments by means of an appliance in conjunction with an osteotomy. While it is apparent that DO has enormous potential for correction of maxillofacial problems, especially some of the major craniofacial syndromes, no extensive long-term data exists to document its precise role in more routine maxillofacial deformities. The indications considered under this policy for DO involves the basal bone (other than the palate) of the jaw only and are limited to conditions in which this technique may be uniquely able to produce significant improvement over more traditional therapy.

Autogenous and alloplastic grafts of bone are considered adjunctive procedures associated with orthognathic surgery. Orthognathic surgery is usually performed under general anesthesia as an inpatient procedure, although some limited and adjunctive procedures may be done on an outpatient basis.

Oral surgical splints may be incidental to the orthognathic procedure when performed during the same operative session or the impression and the custom preparation of the splint may be completed prior to the primary surgical procedure. An impression is made of the area, and the
physician customizes the splint from the case model of the impression. This is a splint which is inserted into the mouth to promote proper healing of the upper and/or lower jawbones after surgery. The splint is fabricated from acrylic or other material.

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**Regulatory Status**

N/A

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**Medical Policy Statement**

The safety and effectiveness of orthognathic surgery have been established. This is a therapeutic option for the correction of severe functional deformities of the jaws, facial skeleton and/or associated soft tissues when specific criteria are met.

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**Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)**

**Basic Criteria (must meet all):**
- Inability to masticate (chew effectively)
- Reports of cephalometric studies documenting developmental skeletal discrepancies of the maxilla and mandible that cannot be corrected by non-surgical procedures. Cephalometric and other radiographic studies should demonstrate severe deviations from the norm sufficient to preclude other than surgical correction.
- Failure of conservative treatment (e.g., continuous positive airway pressure [CPAP], oral appliance)
- The abnormality involves the jaws, facial skeleton and/or associated soft tissues.
- The abnormality is a result of genetic, environmental, developmental, functional and/or pathologic apparent at birth or manifested in subsequent growth and development or acquired through trauma, neoplastic processes and/or degenerative diseases.

**Supporting Criteria (must meet one):**
- A diagnosis of obstructive sleep apnea
- A deformity that prevents the patient to close the lips while in repose (lip incompetency)
- A deformity that impacts the patient’s speech
- A deformity in which surgical intervention would provide improved functional status
CPT/HCPCS Level II Codes (Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)

**Established codes:**

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**Other codes (investigational, not medically necessary, etc.):**

N/A

Note: The above code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

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**Rationale**

Evidence has shown that orthognathic surgery can result in significant improvement in skeletal deformities that affect one’s chewing, breathing, speaking and swallowing. This surgery is considered reconstructive, as it is performed to correct a functional defect. When conservative therapy is not able to resolve the functional problem associated with a deformity, orthognathic surgery may be necessary to bring the jaws and dental arches into alignment. The evidence to support this conclusion includes non-randomized controlled trials and case series studies.

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**Government Regulations**

**National:**

There is no National Coverage Determination for orthognathic surgery.

**Local:**

There is a Local Coverage Determination (L34526) titled “Surgical Treatment of Obstructive Sleep Apnea (OSA)”, Revision Effective Date 12/1/18

**Coverage Indications, Limitations, and/or Medical Necessity**

Surgical treatment often referred to as Obstructive Sleep Apnea (OSA), is characterized by frequent episodes of hypopnea or apnea during sleep. Multiple detrimental physiologic changes may result from these hypopneic and apneic episodes. Non-surgical and surgical approaches to obstructive apnea and hypopnea have been developed.
Continuous Positive Airway Pressure (CPAP) breathing is the treatment of choice for OSA. Some patients do not tolerate CPAP, or are not benefited from it. The level of obstruction in OSA (retropalatal, retrolingual, and retropalatal and retrolingual) is variable.

Uvulopalatopharyngoplasty (UPPP) is an accepted means of surgical treatment for this disorder, but is curative in less than 50% of patients. Scientific evidence suggests that UPPP is useful in retropalatal and combination retropalatal and retrolingual obstruction.

Mandibular Maxillary Osteotomy and Advancement is a procedure developed for those patients with retrolingual obstruction, or those patients with retropalatal and retrolingual obstruction who have not responded to CPAP and uvulopalatopharyngoplasty. Medical data on the efficacy of this treatment has been reported from only a small number of centers, but the information appears to show good results for those patients who meet certain criteria. It is unknown whether the technique will result in similar results outside specialized centers.

Tracheostomy remains the surgical approach with the greatest effectiveness since it bypasses all areas of obstruction in the nasal, palatal, lingual, and pharyngeal areas. However, tracheostomy is associated with significant morbidity, and is usually reserved for patients who have failed other medical or surgical methods of treatment, or who are unsuitable for other methods of treatment for various reasons.

Various other anatomic abnormalities (such as, but not limited to, enlarged tonsils or tongue) sometimes cause OSA also. Surgical approaches to these abnormalities will vary according to the anatomic defect and the procedure/procedures needed to correct the defined problem.

Genioglossal advancement, with or without resuspension of the hyoid bone, may be performed with uvulopalatopharyngoplasty, but this procedure is not always successful, and there is little definitive information on its benefit.

A. Uvulopalatopharyngoplasty (UPPP) is covered for those patients who have all of the following:
   1. Obstructive sleep apnea diagnosed (prior to any proposed surgery) in a certified sleep disorders laboratory (certification body recognized by the American Academy of Sleep Medicine);
   2. A Respiratory Disturbance Index of 15 or higher
   3. Failed to respond to Continuous Positive Airway Pressure therapy or cannot tolerate CPAP or other appropriate non-invasive treatment;
   4. Documented counseling by a physician, with recognized training in sleep disorders, about the potential benefits and risks of the surgery; and
   5. Evidence of retropalatal or combination retropalatal/retrolingual obstruction as the cause of the obstructive sleep apnea.

B. Mandibular Maxillary Osteotomy and Advancement and/or genioglossus advancement with or without hyoid suspension is covered for those patients who have all of the following:
1. Obstructive sleep apnea diagnosed (prior to any proposed surgery) in a certified sleep disorders laboratory (certification body recognized by the American Academy of Sleep Medicine);

2. A Respiratory Disturbance Index of 15 or higher;

3. Failed to respond to Continuous Positive Airway Pressure therapy or cannot tolerate CPAP or other appropriate non-invasive treatment;

4. Documented counseling by a physician, with recognized training in sleep disorders, about the potential benefits and risks of the surgery; and

5. Evidence of retrolingual obstruction as the cause of the obstructive sleep apnea, or previous failure of UPPP to correct the obstructive sleep apnea.

Regarding the Mandibular Maxillary Osteotomy and Advancement operation:

a. Separate repositioning of teeth would not be necessary except under unusual circumstances; but if necessary the dental work would be covered.

b. Application of an interdental fixation device is occasionally necessary, and is a covered service (see Documentation Requirements).

C. Tracheostomy is covered for obstructive sleep apnea that is in the judgment of the attending physician, unresponsive to other means of treatment or in cases where other means of treatment would be ineffective or not indicated.

D. When obstructive sleep apnea is caused by discrete anatomic abnormalities of the upper airway (such as, but not limited to, enlarged tonsils or an enlarged tongue), surgery to correct these abnormalities is covered if medically necessary based on adequate documentation in the medical records supporting the significant contribution of these abnormalities to OSA. Submucous radiofrequency reduction of hypertrophied turbinates is covered as an appropriate treatment for nasal obstruction due to turbinate hypertrophy that significantly contributes to OSA or significantly compromises CPAP therapy.

E. The following procedures are not covered at this time

1. Laser-assisted uvulopalatoplasty (LAUP) is not covered at this time since it is not considered effective for OSA. LAUP must not be billed as 42145, Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty). This code is not appropriate for this procedure. If LAUP is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "LAUP" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form. The claim will be denied as not proven effective.

2. Somnoplasty™ is a trade name for palate reduction with the Somnoplasty™ System of Somnus Medical Systems. This is not a term recognized by this Contractor as a covered procedure under Medicare Part B. Therefore Somnoplasty™ must not be billed as 42145. This code is not appropriate for this procedure. If Somnoplasty™ is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "Somnoplasty™" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form. This claim will be denied as not proven effective.
3. The Pillar Procedure™ is a trade name for palatal implants. Palatal implants have not been shown effective for the treatment of obstructive sleep apnea and are not covered. This procedure should be billed by the physician as 42299 (unlisted procedure, palate, uvula) with "Pillar Procedure™" or "palatal implant" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form. This claim will then be denied as not proven effective. Hospital outpatient would use code C9727.

4. Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session. (41530) will be denied as investigational and experimental.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

• Cosmetic and Reconstructive Surgery
• Obstructive Sleep Apnea and Snoring – Surgical Treatment
• Oral Surgery

References

7. Wisconsin Physicians Service Insurance Corporation, Contract Number 08202, Local Coverage Determination (LCD): Surgical Treatment of Obstructive Sleep Apnea (OSA) (L34526), Original effective date 10/1/15, Revision effective date 1/1/18; retrieved July 19, 2018 from: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCID=34526&ver=12&SearchType=Advanced&CoverageSelection=Both&NCSSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cE
The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 4/9/19, the date the research was completed.
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Next Review Date: 2nd Qtr, 2020
BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: ORTHOGNATHIC SURGERY

I. Coverage Determination:

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<td>Covered, policy guidelines apply</td>
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<td>BCNA (Medicare Advantage)</td>
<td>Refer to Medicare guideline section.</td>
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<td>BCN65 (Medicare Complementary)</td>
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II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member’s certificate and is not guaranteed. Please consult the individual member’s certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member’s PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.