ORTHOGNATHIC SURGERY

The purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for orthognathic surgery. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Orthognathic surgery is the surgical correction of abnormalities of the mandible (lower jaw), the maxilla (upper jaw), or both. The underlying abnormality may be present at birth or may become evident as the patient grows and develops or may be the result of traumatic injuries. The primary goal of treatment is to improve function through correction of the underlying skeletal deformity.

CLINICAL GUIDELINE

Coverage guidelines for orthognathic surgery are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and their clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Orthognathic surgery may be considered medically necessary in the presence of any of the following facial skeletal deformities associated with masticatory malocclusion after undergoing corrective orthodontics:

1. Congenital or traumatic anomalies that meet the criteria for reconstruction depending on the member’s age, state of development and a patient-specific clinical review, examples include but are not limited to:
   a. Cleft palate;
   b. Midface hypoplasia;
   c. Mandibular prognathism;
   d. Hemifacial microsomia; or
   e. Traumatic events.

Orthognathic surgery may be considered medically necessary when the individual is undergoing active orthodontic treatment and meets the defined criteria for severe handicapping malocclusion where the malocclusion cannot be solely corrected through orthodontic treatment:

1. Significant antero-posterior facial skeletal discrepancies are defined as:
   a. A maxillary/mandibular incisor relationship with an overjet of 5mm or greater or a negative value
   b. A maxillary/mandibular antero-posterior molar relationship discrepancy of 4mm or greater

2. Significant transverse facial skeletal discrepancies are defined as:
   a. A transverse skeletal discrepancy which is 2 or more standard deviations from published
Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the Benefit and Authorization Grids summaries on www.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.
NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization for orthognathic surgery is required. Requests for coverage of orthognathic surgery will be reviewed in accordance with procedures in place for reviewing requests for outpatient surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for orthognathic surgery:
1. Fully completed Outpatient Prior Authorization Request Form.
2. Clinical documentation including, but not limited to:
   a. Diagnostic and predictive imaging including cephalometric tracings where applicable;
   b. A thorough description of the anomalies including a detailed description of all functional impairments;
   c. Supporting diagnostic testing;
   d. Facial photographs that are properly oriented; and
   e. The quantification of the planned surgical movement(s).
3. Other information as requested.

EFFECTIVE DATE
This Policy is effective for prior authorization requests for orthognathic surgery for individuals covered under the HUSKY Health Program beginning August 1, 2017.

LIMITATIONS
N/A

CODES:
Please refer to the dental fee schedules posted to the Connecticut Medical Assistance Program (CMAP) web site for a listing of codes pertaining to this policy.

DEFINITIONS
1. HUSKY A: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. HUSKY B: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.

4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).

5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.

6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.

7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

**RESOURCES AND REFERENCES:**

**PUBLICATION HISTORY**

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