# PROVIDER POLICIES & PROCEDURES

## ORTHOGNATHIC (JAW) SURGERY AND ASSOCIATED PROCEDURES

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 and associated procedures. 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 performed to surgically correct abnormalities of the facial bones, specifically the lower jaw (mandible) and upper jaw (maxilla). Severe problems with the lower and upper jaws can interfere with being able to speak or chew. 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. Some of these corrective surgeries involve lengthening or shortening the lower jawbone.

HUSKY Health primarily uses InterQual® criteria when reviewing prior authorization requests for coverage of orthognathic surgery and most associated procedures. HUSKY Health will use this policy to review requests for orthognathic surgery and associated procedures for which InterQual® criteria are not available.

Please refer to the **HUSKY Health Temporomandibular Joint (TMJ) Disorder Surgery and Associated Procedures** policy for coverage guidelines related to temporomandibular joint (TMJ) disorders.

Please refer to the **Cosmetic Surgery** policy for coverage guidelines related to genioplasty.

### CLINICAL GUIDELINE

Coverage guidelines for orthognathic surgery and associated procedures 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:

**Oral Surgical Splint (CPT code 21085)**
An oral surgical splint is considered medically necessary when used in conjunction with a medically necessary orthognathic procedure.

**Interdental Fixation (CPT code 21110)**
Application, including removal, of interdental fixation for conditions other than a fracture or dislocation is

considered medically necessary when it is being performed as an adjunct to surgical repositioning with an orthognathic procedure.

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 and associated procedures is required. Requests for coverage of orthognathic surgery and associated procedures will be reviewed in accordance with procedures in place for reviewing requests for 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 an oral surgical splint (CPT code 21085) and interdental fixation (CPT code 21110):

1. Fully completed authorization request via on-line web portal;
2. Clinical documentation as outlined in the *Clinical Guideline* section from the requesting physician, APRN, or PA supporting the medical necessity of the requested associated procedure; and
3. Other information as requested.

**EFFECTIVE DATE**
This Policy is effective for prior authorization requests of orthognathic surgery and associated procedures for individuals covered under the HUSKY Health Program beginning August 1, 2025.

**LIMITATIONS**
N/A

**CODES**

**Reviewed Using Policy**

| Code | Description |
|---|---|
| 21085 | Impression and custom preparation; oral surgical splint |
| 21110 | Application of interdental fixation device for conditions other than fracture or dislocation, includes removal |

**Reviewed Using InterQual® Criteria**

| Code | Description |
|---|---|
| 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; 2 pieces, segment movement in any direction, |

| | |
|---|---|
| | without bone graft |
| 21143 | Reconstruction midface, LeFort I; 3 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; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft) |
| 21147 | Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies) |
| 21150 | Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome) |
| 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 (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I |
| 21160 | Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I |
| 21188 | Reconstruction of 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) |
| 21210 | Graft, bone; nasal, maxillary or malar areas (includes obtaining graft) |
| 21215 | Graft, bone; mandible (includes obtaining graft) |

**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:**


- Abrahamsson C, Henrikson T, Bondemark L, Ekberg E. Masticatory function in patients with dentofacial deformities before and after orthognathic treatment-a prospective, longitudinal, and controlled study. Eur J Orthod. 2015;37(1):67-72. doi:10.1093/ejo/cju011
- American Association of Oral and Maxillofacial Surgeons. Clinical Paper. Criteria for Orthognathic Surgery. 2023. Available at: https://www.aaoms.org/docs/practice_resources/clinical_resources/ortho_criteria.pdf. Accessed February 13, 2025.
- American Association of Oral and Maxillofacial Surgeons. Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery. 2017. Available at: http://www.aaoms.org/images/uploads/pdfs/parcare_assessment.pdf . Accessed February 13, 2025.
- Baker NJ, David S, Barnard DW, Birnie DJ, Robinson SN. Occlusal outcome in patients undergoing orthognathic surgery with internal fixation. Br J Oral Maxillofac Surg. 1999;37(2):90-93. doi:10.1054/bjom.1998.0432
- Brandtner C, Hachleitner J, Rippel C, Krenkel C, Gaggl A. Long-term skeletal and dental stability after orthognathic surgery of the maxillo-mandibular complex in Class II patients with transverse discrepancies. J Craniomaxillofac Surg. 2015;43(8):1516-1521. doi:10.1016/j.jcms.2015.07.007
- Bunpu P, Changsiripun C. Assessment of masticatory performance in patients undergoing

orthognathic surgery: A systematic review and meta-analysis. J Oral Rehabil. 2023 Jul;50(7):596-616.
- Mulier D, Gaitán Romero L, Führer A, et al. Long-term dental stability after orthognathic surgery: a systematic review. Eur J Orthod. 2021 Jan 29;43(1):104-112.

**PUBLICATION HISTORY**

| Status | Date | Action Taken |
|---|---|---|
| Original Publication | May 2025 | Approved at the May 28, 2025, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on June 16, 2025. Approved by DSS on July 9, 2025. |