PROVIDER POLICIES & PROCEDURES

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

norms; **or**
    b. A unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or
    c. Complete bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater.
3. Significant vertical facial skeletal discrepancies are defined as:
    a. The presence of a vertical facial skeletal deformity which is 2 or more standard deviations from published norms for skeletal landmarks;
    b. Open bite with no vertical overlap of the anterior teeth;
    c. Unilateral or bilateral posterior open bite greater than 2mm;
    d. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or
    e. Super-eruption of a dentoalveolar segment due to lack of occlusion.
4. Asymmetries defined as antero-posterior transverse or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry.

Orthognathic surgery may also be considered medically necessary for restoration of function following significant accidental injury, infection or tumor.

In addition to meeting the above criteria, the individual must typically display **one or more** of the following impairments:

1. Masticatory dysfunction due to skeletal malocclusion (e.g., inability to incise/and or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication)
2. Speech abnormalities determined by a speech pathologist or therapist to be due to a malocclusion and not helped by orthodontia or at least 6 months of speech therapy
3. Moderate to Severe sleep apnea caused by airway obstruction as measured by polysomnography (AASM Obstructive Sleep Apnea and Practice Parameters for the Surgical Modifications of the Upper Airway for Obstructive Sleep Apnea in Adults) when the following criteria are met:
    a. AHI or RDI $\geq$ 15 and $\leq$ 30 (moderate obstruction) or AHI or RDI > 30/hr (severe obstruction); **and**
    b. Documentation of hypopharyngeal obstruction; **and**
    c. The individual has proved intolerant to or has "failed" a trial of positive airway pressure (PAP)*; and
    d. A mandibular advancement splint or tongue-retaining appliance has been considered and found to be ineffective.
4. Difficulty swallowing as determined by the following conditions:
    a. Significant weight loss and/or failure to thrive documented in the records over 4 months; **or**
    b. Low Body Mass Index (BMI) defined as BMI < 20; **or**
    c. Low serum albumin related to malnutrition.
5. Documented temporomandibular joint pathology

*****Failure is defined as compliance with the positive airway pressure device (use of the device for 4 or more hours per night on 21 out of 30 nights during a consecutive 30 day period) with moderate to severe apnea/hypopnea occurring during usage. A download from the device must be submitted with the request for surgery.

Not Medically Necessary
The following are typically considered ***not*** medically necessary but may be considered medically necessary after an individualized, person-centered review:

- When the procedure is intended to change a physical appearance that would be considered within normal human anatomic variation.
- When the procedure is performed to correct malocclusion when the listed deviations from normal variations are not met.
- When the individual is not undergoing active orthodontic treatment.
- Frenulectomy to correct anklyoglossia (tongue-tie) in breast feeding infants displaying normal growth and development

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:

- American Association of Oral and Maxillofacial Surgeons (AAOMS). Clinical Paper. Criteria for Orthognathic Surgery. 2017. Available at: https://www.aaoms.org/docs/practice_resources/clinical_resources/ortho_criteria.pdf
- DSS Provider Bulletin 2016:73 : Clarification of Orthognathic Surgery Medical Necessity Definitions – Surgery Codes dated November 2016

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	June 2017	Approved by Medical Policy Review Committee on May 10, 2017. Approved by Clinical Quality Subcommittee on June 20, 2017. Approved by DSS on July 14, 2017.
Update	June 2018	Updated to reflect current criteria for orthognathic surgery from the American Association Of Oral and Maxillofacial Surgeons. Added Temporomandibular joint pathology to list of conditions/impairments associated with facial-skeletal discrepancies (page 2 of policy). Change approved at the May 28, 2018 Medical Policy Review Committee meeting. Change approved by the CHNCT Clinical Quality Subcommittee on June 18, 2018. Approved by DSS on June 20, 2018.
Review	May 2019	Reviewed without changes at the May 8, 2019 Medical Reviewer Meeting. Approved by the CHNCT Clinical Quality Subcommittee on June 19, 2019. Reviewed by DSS. Updates made to the Clinical Guideline section. Clarified need for a failed trial of PAP and mandibular advance splint or tongue-retaining appliance prior to orthognathic surgery for obstructive sleep apnea. Added language regarding frenulectomies in breastfeeding infants with anklyoglossia with normal growth and development as not medically necessary. Changes approved by DSS on June 28, 201
Review	June 2020	Reviewed without changes at the June 10, 2020 Medical Reviewe Meeting. Approved without changes by the CHNCT Clinical Quality Subcommittee on June 15, 2020. Approved by DSS on June 19, 2020.
Review	June 2021	Reviewed without changes at the May 12, 2021 Medical Reviewer meeting. Reviewed and approved without changes at the June 21, 2021 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on June 28, 2021.
Review	June 2022	Reviewed and approved without changes at the April 27, 2022 CHNCT Medical Reviewer meeting. Reviewed and approved without changes by the CHNCT Clinical Quality Subcommittee on June 20, 2022. Approved by DSS on July 5, 2022.