

**Policy is terminated because coverage is provided under the combined  
Medicaid and NCHC 4A, Dental Services**

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## **1.0 Description of the Procedure, Product, or Service**

Orthognathic surgery is the surgical correction of abnormalities of the mandible, maxilla, or both. The underlying abnormality may be caused by congenital or developmental conditions, acquired disturbances or trauma, infection, or neoplasm.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

To be eligible, NCHC recipients must be enrolled on the date of service.

## **3.0 When the Procedure, Product, or Service Is Covered**

### **3.1 General Criteria**

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### **3.2 Specific Criteria**

Orthognathic surgery is considered to be medically necessary and eligible for coverage when the following criteria are met.

- a. The surgery is the only method that will correct the deformity;
- b. Surgery is not being done for cosmetic reasons; and
- c. The proposed surgery is for one or more of the medical indications outlined below with medical record documentation from evaluating and treating providers demonstrating that criteria below related to that condition are fulfilled:
  1. Repair of congenital anomalies (cleft lip or palate and other similar anomalies):
    - (a) Le Fort III and orbital osteotomy procedures are considered medically necessary to treat congenital disorders producing mid-face hypoplasia (i.e. Crouzon syndrome, Apert Syndrome, Pfeiffer Syndrome, cleft deformity, etc.) that have resulted in disorders of the eyes (eye muscle dysfunction, corneal exposure/corneal ulceration, globe herniation, visual acuity loss) respiratory problems (nasal airway obstruction, sleep apnea.)

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**Applicable FARS/DFARS apply.**

unintelligible speech (sibilant distortions or velopharyngeal distortion) not amenable to speech therapy.

- (b) Mandibular surgery (intraoral vertical ramus osteotomy, bilateral sagittal split ramus osteotomy, mandibular osteotomy, can be considered medically necessary to treat congenital micrognathia resulting in respiratory obstruction (i.e. Pierre Robin Syndrome) or maxillary deficiency associated with cleft deformities.
  - (c) Le Fort I for congenital disorders will be considered on an individual basis.
2. Restoration of function following treatment for significant accidental injury, infection, or tumor.
  3. Treatment of malocclusion that contributes to unresolved temporomandibular joint disorder (TMJD) symptoms. The recipient must have findings meeting the criteria in (a) i and ii below and there must also have been failure of a trial of all the conservative measures listed below, as documented in medical records by the evaluating and treating health care providers.
    - (a) Findings
      - i. At least one of the following symptoms for at least 4 months:
        - (A.) Painful chewing clearly related to TMJD;
        - (B.) Frequent and significant headaches clearly related to TMJD; **OR**
        - (C.) Significant and persistent joint and/or muscle tenderness;

**AND**

      - ii. At least one of the following clinical signs [Note that measurements of reverse overjet, overjet, openbite, and deep bite should be calculated without assuming the final results for the preoperative orthodontics or splinting]:
        - (A.) Class III or IV internal derangement of the TMJ; **OR**
        - (B.) Restricted range of motion, including at least one of the following:
          - (1.) Intercisional opening <30mm (mouth opening)
          - (2.) Lateral excursive movement <4mm (side to side motion)
          - (3.) Protrusive excursive movement <4mm (front to back motion); **OR**
        - (C.) Significant overjet or underjet(one of the following):
          - (1.) For recipients with mandibular excess or maxillary deficiency or reverse overjet(underbite) of at least 3mm
          - (2.) In mandibular deficiency an overjet of at least 6mm.
          - (3.) Open bite of at least 4mm and deep bite of at least 7mm.

**AND**

- (b) Symptoms are unresponsive to conservative measures including ALL of the following:
- i. Elimination of aggravating factors (e.g.; gum chewing, chewing of hard or tough foods);
  - ii. Use of inflammatory drugs unless contraindicated. Therapeutic level for at least 6 weeks; **AND**
  - iii. Orthodontic and/or splint therapy [Note: in many cases orthodontic treatment alone cannot correct the abnormality. When it has been determined in advance by cephalometrics and clinical examination that no amount of orthodontic manipulation will achieve satisfactory results, then a failed course of orthodontic therapy will not be a prerequisite for approval for surgery. Likewise, some recipients with large open bites cannot tolerate splints, as this actually aggravates the problem].
- d. Treatment of malocclusion that contributes significantly to any of the following conditions AND has failed at least 4 months of non-operative therapy:
1. Speech abnormality when both of the following criteria are met:
    - (a) Speech deficit is noticeable to a lay person or primary care physician and significantly impairs the recipient's ability to communicate. (Disturbance or impairment of sibilant sound class is not considered a significant functional impairment.); **AND**
    - (b) The speech deficit cannot be resolved by speech therapy (requires speech therapy evaluation); **OR**
  2. Malnutrition related to choking, difficulty swallowing, or an inability to masticate that results in either one of the following:
    - (a) Significant weight loss documented in the medical record over 4 months; or
    - (b) Low serum albumin related to malnutrition;

**OR**
  3. Significant intraoral trauma while chewing related to malocclusion. (Information should be supplied which indicates the severity and duration of the trauma and the extent of the interruption to daily activities. This may include recurrent damage to the soft tissues of the mouth during mastication, lower incisors injuring the soft tissue of the palate, cheek biting, lip biting, impingement or irritation of buccal or lingual soft tissues of the opposing arch. The injury or damage to soft tissues must be documented by objective findings in the medical record and supported by photos.)
- e. Adjunctive treatment for obstructive sleep apnea (OSA). Hyoid suspension, surgical modification of the tongue (including genioglossus advancement), and/or maxillofacial surgery, including mandibular-maxillary advancement (MMA), may be

considered medically necessary in recipients when **ALL** of the following criteria are met:

1. Clinically significant OSA (documentation of findings from a sleep study is required);
2. Objective documentation of hypopharyngeal obstruction by physical examination;
3. Documentation of trial and failure of a good faith effort at treatment with CPAP, BiPAP or DPAP; **AND**
4. orthognathic surgery will not be approved as the first surgery for OSA unless otolaryngology evaluation has ruled out obstruction at a higher anatomic level (i.e., nose, palate).

**Note:** Effective July 1, 2009 coverage is also provided for orthognathic surgery to correct functionally impairing malocclusions when presurgical orthodontics was approved and initiated while the child was covered by Medicaid and the need for orthognathic surgery was documented in the orthodontic treatment plan at the time of the orthodontic treatment approval.

## 4.0 When the Procedure, Product, or Service Is Not Covered

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

### 4.2 Specific Criteria

- a. No benefits are available for dental care except as specified in NC General Statutes (Refer to the NC Health Choice recipient Handbook).
- b. Except as specified in **Subsection 3.2**, treatment of significant malocclusion in the absence of significant, current medical complication that has not been amenable to other forms of treatment, is not covered under the NCHC program, even if the malocclusion cannot be effectively corrected with orthodontic treatment alone.
- c. Orthognathic surgery is not covered where significant risk of recurrence of symptoms or structural abnormalities exist. For treatment of mandibular excess, skeletal maturation must be documented by either:
  1. closure of the epiphyses at the wrist by radiography; **OR**
  2. no change on mandibular or facial growth on serial cephalometric radiographs over six months
- d. Genioplasty (horizontal osteotomy of the mandible) is considered cosmetic and is not eligible for benefit.

- e. Cosmetic enhancement of facial features (eg., mentoplasty and chin augmentation) is noncovered.
- f. Congenital disorders other than as noted under **Subsection 3.2** will be reviewed on an individual consideration basis.

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

- a. Prior Approval is required for Orthognathic Surgery.
- b. A letter of medical necessity signed and dated by the surgeon prior to performing the surgery must be submitted to DMA's vendor prior to performing the surgery.
- c. Approval for the procedure(s) cannot occur if information supplied does not substantiate medical necessity based on the Medical Policy criteria, and also because orthognathic surgery performed to treat malocclusion without the associated medical causes, circumstances, or consequences is noncovered dental care under the NC Health Choice Program.
- d. Documentation must include:
  - 1. Recipient demographics (ID and mailing address)
  - 2. Reasons for the surgery, substantiated by copies of the recipient's records to include history, examination, and prior non-surgical treatment; medical records from the oral/maxillofacial surgeon and from all other providers who have previously evaluated and treated the recipient for malocclusion and any associated medical problems must be submitted.
  - 3. Preoperative panorex and cephalometric x-rays, lateral, full-face, and occlusal photographs, and cephalometric analysis and predictions, made before any previous orthodontic treatment or orthognathic surgeries. (Additionally, for treatment of TMJD, MRI scan results are desirable, if performed. If not performed, other evidence documenting the stage of internal derangement, should be provided).
  - 4. Plans for pre-operative, operative, and post-operative treatment.

### 5.2 Other

- a. If the purpose of surgery is to correct the recipient's malocclusion, this is considered dental care by the NCHC program. Dental care benefits under the NCHC Program as specified in NC General Statutes of the Predecessor Plan and in Chapter 108A-70.21(b)] do not include benefits for orthognathic surgery for correction of dental malocclusion even though it may be advisable from a dental perspective. The sole exception is that effective July 1, 2009, the statutes also provide coverage for orthognathic surgery on an individual exception basis in cases where pre-surgical orthodontics was approved and initiated while the child was covered by Medicaid and the need for orthognathic surgery was documented in the orthodontic treatment plan at the time of that approval.

- b. There are, however, very specific instances in which NC Health Choice Program non-dental benefits are available for orthognathic surgery. NC Health Choice Medical Policy is designed to ensure that the NC Health Choice program benefits are applied for medical rather than dental conditions

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

## 7.0 Additional Requirements

### 7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** July 1, 2010

**Revision Information:**

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, <b>Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.</b>
June 14, 2012	Throughout	Policy Termination

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

### A. Claim Type

Professional (CMS-1500/837P transaction)

Dental (2006 ADA Claim Form/837D transaction)

### B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

### C. Procedure Code(s)

Facial construction				
CPT Codes				
21085	21141	21142	21143	21145
21146	21147	21194	21196	21198

Orthognathic surgery				
CDT Codes				
D7940	D7941	D7943	D7944	D7945
D7946	D7947	D7948	D7949	D7950
D7955				

### D. Modifiers

Providers are required to follow applicable modifier guidelines when billing CPT codes.

### E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

### F. Place of Service

Inpatient Hospital, Outpatient Hospital, Ambulatory Surgical Center (ASC), and Office

### G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

### H. Reimbursement

Providers must bill their usual and customary charges.