



BlueShield  
of Northeastern New York

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# Protocol

## Orthognathic Surgery

Effective January 1, 2006

**Contracts Affected:**  
**All Community Blue HMO**  
**Senior Blue/Medicare PPO**  
**Traditional Blue**

*The following protocol contains medical necessity criteria for Orthognathic Surgery services rendered on or after January 1, 2006 for BlueShield of Northeastern New York (BlueShield) contracts. If these criteria are not met, reimbursement will be denied and the patient cannot be billed. **Prior approval is required.** Please note that payment for covered services is subject to the limitations noted in the above-referenced contracts and the patient's eligibility at the time the services are rendered.*

### Description

Orthognathic surgery is the surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw) or the maxilla (upper jaw). These malformations may be present at birth, or they may become evident as the patient grows and develops.

Jaw malformations can cause chewing and eating difficulties, abnormal speech patterns, early loss of teeth, and disfigurement and dysfunction of the temporomandibular joint. Malocclusion (abnormal jaw relation) may be caused by a deficiency or excess of bony tissue in one or both jaws, or by trauma to the facial bones.

### Corporate Medical Guideline

Orthognathic surgery is **medically appropriate** for correction of the following skeletal deformities of the maxilla or mandible when it is documented that these skeletal deformities are contributing to significant dysfunction, and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics alone:

- 1) Maxillary and/or mandibular facial skeletal deformities associated with masticatory malocclusion when it is documented that these skeletal deformities are contributing to significant masticatory dysfunction:
  - a) Anteroposterior discrepancies:
    - i) Maxillary/mandibular incisor relationship: overjet of 5 mm or more, or a 0 to a negative value (norm 2 mm), and
    - ii) Maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm 0 to 1 mm).

**Note:** These values represent two or more standard deviation from published norms.
  - b) Vertical discrepancies:
    - i) Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks,
    - ii) Open Bite:
      - (1) No vertical overlap of anterior teeth, and
      - (2) Unilateral or bilateral posterior open bite greater than 2 mm,
    - iii) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing

arch, and

- iv) Supraeruption of a dentoalveolar segment due to lack of occlusion.
- c) Transverse discrepancies:
- i) Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms, and
  - ii) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.
- d) Asymmetries:
- i) Anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry.
- 2) Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies when it is documented that intervention with surgical means will decrease airway resistance and improve breathing. For example, studies demonstrate that patients with vertical hyperplasia of the maxilla have an associated increase in nasal resistance, as do patients with maxillary hypoplasia with or without clefts. Following orthognathic surgery, such patients routinely demonstrate decreases in nasal airway resistance and improved respiration.

Orthognathic surgery is **medically appropriate** for patients with underlying craniofacial skeletal deformities that are contributing to obstructive sleep apnea. Before surgery, such patients should be properly evaluated to determine the cause and site of their disorder and appropriate non-surgical treatments attempted when indicated.

- 3) Temporomandibular joint pathology: skeletal malocclusion related to TMJ dysfunction. Prior to performing an orthognathic procedure, non-surgical therapies should be attempted, including those procedures and treatments that mimic the effects of occlusal alteration.
- 4) Facial skeletal discrepancies associated with documented speech impairments. Altered speech production may be associated with facial skeletal deformities; the most common impairment is a distortion within the sibilant sound class. Prior to surgery, speech evaluation should be obtained to demonstrate the nature of the problem and to determine if improvement can be expected.

Orthognathic surgery is considered cosmetic and **not medically appropriate** for correction of unaesthetic facial features, regardless of whether these are associated with psychological disorders. Mentoplasty or genial osteotomies/ostectomies (chin surgeries) are always considered cosmetic and **not medically appropriate** when performed as an isolated procedure to address genial hypoplasia, hypertrophy, or asymmetry.

Prior approval is required. BlueShield fully expects that only appropriate and medically necessary services will be rendered. BlueShield reserves the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures.

## References

1. American Association of Oral and Maxillofacial Surgeons (AAOMS), Criteria for orthognathic surgery, Reimbursement and Appeal Resources, Health Policy and Third Party Payer Relations Resources, Rosemont, IL: AAOMS;2002. [http://www.aaoms.org/ortho\\_criteria.php](http://www.aaoms.org/ortho_criteria.php), accessed 8/07.
2. American Society of Plastic and Reconstructive Surgeons, Orthognathic Surgery: Recommended Criteria for Third-Party Payer Coverage, Arlington Heights, IL: ASPRS, September 1997.

### Last Review Date

Reviewed with literature search/September 2007

### Next Review Date

Review with literature search/September 2008