

# Orthognathic (Jaw) Surgery

**Guideline Number:** MMG095.T  
**Effective Date:** June 1, 2024

[➔ Instructions for Use](#)

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| Related Medical Management Guidelines   |
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| <ul style="list-style-type: none"> <li>• <a href="#">Obstructive and Central Sleep Apnea Treatment</a></li> <li>• <a href="#">Treatment of Temporomandibular Joint Disorders</a></li> </ul> |

## Coverage Rationale

[➔ See Benefit Considerations](#)

This policy does not address surgical treatment for obstructive sleep apnea or temporomandibular joint disorders. Refer to the Medical Management Guideline titled [Obstructive and Central Sleep Apnea Treatment](#) or [Treatment of Temporomandibular Joint Disorders](#).

**Orthognathic (jaw) surgery may be considered reconstructive and medically necessary when the following criteria are met:**

- The presence of one or more of the following facial skeletal deformities associated with masticatory malocclusion:
  - Anteroposterior discrepancies (established norm = 2 mm), with one of the following:
    - Maxillary/mandibular incisor relationship: Horizontal overjet of 5 mm or more or a 0 to a negative value; or
    - Maxillary/mandibular anteroposterior molar relationship: Discrepancy of 4 mm or more (norm 0 to 1 mm)

**Note:** These values represent two or more standard deviations from published norms.
  - Vertical discrepancies with one of the following:
    - Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks; or
    - Open bite with one of the following:
      - No vertical overlap of anterior teeth; or
      - Unilateral or bilateral posterior open bite greater than 2 mm; or
    - Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or
    - Supraeruption of a dentoalveolar segment due to lack of occlusion
  - Transverse discrepancies, with one of the following:
    - Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms; or
    - Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth
  - Asymmetries: Anteroposterior, transverse, or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry
- and
- The member must also have one or more of the following [Functional Impairments](#):

- Masticatory and swallowing dysfunction due to skeletal malocclusion (e.g., inability to bite and/or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition); or
- Documentation of speech impairment due to facial skeletal deformity

Orthognathic surgery is not considered **reconstructive** and medically necessary for all other indications, including when performed for **cosmetic** purposes only.

## Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

| Required Clinical Information   |
|---|
| <p><b>Orthognathic (Jaw) Surgery</b></p> <p>Medical notes documenting the following, when applicable:</p> <ul style="list-style-type: none"> <li>● Condition requiring procedure</li> <li>● Comprehensive history of the medical condition(s) requiring treatment or surgical intervention; including: <ul style="list-style-type: none"> <li>○ A well-defined physical and/or physiological abnormality (e.g., congenital abnormality, functional or skeletal impairments) resulting in a medical condition that has required or requires treatment</li> <li>○ The physical and/or physiological abnormality has resulted in a functional deficit</li> <li>○ The functional deficit is recurrent or persistent in nature</li> </ul> </li> <li>● Reports of all recent imaging studies and applicable diagnostic tests, including: <ul style="list-style-type: none"> <li>○ Cephalometric tracings and analysis addressing the physical and/or physiological abnormality that confirm its presence and the degree to which it is causing impairment, with appropriate measurements, when applicable</li> <li>○ Radiologic image interpretations including lateral cephalometric radiograph, AP radiograph, and panoramic radiograph</li> </ul> </li> <li>● All related, supporting imaging (color photographs, radiologic images including lateral cephalometric radiograph, AP radiograph, and panoramic radiograph) must be diagnostic quality <ul style="list-style-type: none"> <li>○ All images must be labeled with the: <ul style="list-style-type: none"> <li>▪ Date taken</li> <li>▪ Applicable case number obtained at time of notification or member's name and ID number</li> </ul> </li> <li>○ <b>Note:</b> Images can be submitted via the external portal at <a href="http://www.uhcprovider.com/paan">www.uhcprovider.com/paan</a>; faxes will not be accepted</li> </ul> </li> <li>● Treating physician's plan of care including surgical treatment objectives, which must include the expected outcome for the improvement of the functional deficit</li> </ul> |

## Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**Congenital Defect (CA Only):** A condition present at birth.

**Cosmetic Services and Surgery (CA Only):** Cosmetic Surgery and Cosmetic Services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices, and procedures related to Cosmetic Surgery or Cosmetic Services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance.

**Cosmetic Services and Surgery (WA, OR, TX, and OK Only):** Cosmetic Surgery and Cosmetic Services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices, and procedures related to Cosmetic Surgery or Cosmetic Services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance, as influenced by that Member's underlying psychological makeup or psychiatric condition.

**Functional or Physical Impairment:** Physical or Functional or Physiological Impairment causes deviation from the normal function of a tissue or organ. These result in a significantly limited, impaired, or delayed capacity to move,

coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

**Reconstructive Surgery (CA Only):** Reconstructive Surgery to correct or repair abnormal structures of the body caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors, or disease. It includes Medically Necessary dental or orthodontic services that are an integral part of the Reconstructive Surgery for cleft palate procedures. Cleft palate means a condition that may include a cleft palate, cleft lip, or other craniofacial anomalies related with a cleft palate. The purpose of Reconstructive Surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description   |
|----------|---|
| 21076    | Impression and custom preparation; surgical obturator prosthesis  |
| 21079    | Impression and custom preparation; interim obturator prosthesis   |
| 21080    | Impression and custom preparation; definitive obturator prosthesis  |
| 21081    | Impression and custom preparation; mandibular resection prosthesis  |
| 21082    | Impression and custom preparation; palatal augmentation prosthesis  |
| 21083    | Impression and custom preparation; palatal lift prosthesis  |
| 21120    | Genioplasty; augmentation (autograft, allograft, prosthetic material)   |
| 21121    | Genioplasty; sliding osteotomy, single piece  |
| 21122    | Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)   |
| 21123    | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)   |
| 21125    | Augmentation, mandibular body or angle; prosthetic material   |
| 21127    | Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)  |
| 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  |

| CPT Code | Description  |
|----------|--|
| 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); with LeFort I    |
| 21188    | Reconstruction 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 grafts (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)   |
| 21244    | Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)  |
| 21245    | Reconstruction of mandible or maxilla, subperiosteal implant; partial  |
| 21246    | Reconstruction of mandible or maxilla, subperiosteal implant; complete   |
| 21247    | Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)  |

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| CDT Code | Description   |
|----------|---|
| D5934    | Mandibular resection prosthesis with guide flange                                   |
| D5935    | Mandibular resection prosthesis without guide flange                                |
| D5982    | Surgical stent  |
| D5988    | Surgical splint   |
| D7471    | Removal of lateral exostosis (maxilla or mandible)                                  |
| D7472    | Removal of torus palatinus  |
| D7473    | Removal of torus mandibularis   |
| D7490    | Radical resection of maxilla or mandible  |
| D7610    | Maxilla – open reduction (teeth immobilized, if present)                            |
| D7630    | Mandible – open reduction (teeth immobilized, if present)                           |
| D7650    | Malar and/or zygomatic arch – open reduction  |
| D7671    | Alveolus – open reduction, may include stabilization of teeth                       |
| D7680    | Facial bones – complicated reduction with fixation and multiple surgical approaches |
| D7710    | Maxilla – open reduction  |
| D7730    | Mandible – open reduction   |
| D7750    | Malar and/or zygomatic arch – open reduction; Incision required to reduce fracture  |
| D7770    | Alveolus – open reduction stabilization of teeth                                    |
| D7780    | Facial bones – complicated reduction with fixation and multiple approaches          |
| D7940    | Osteoplasty – for orthognathic deformities  |
| D7941    | Osteotomy – mandibular rami   |

| CDT Code | Description   |
|----------|---|
| D7943    | Osteotomy – mandibular rami with bone graft; includes obtaining the graft                                       |
| D7944    | Osteotomy – segmented or subapical  |
| D7945    | Osteotomy – body of mandible  |
| D7946    | Lefort I (maxilla – total)  |
| D7947    | Lefort I (maxilla – segmented)  |
| D7948    | Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft  |
| D7949    | Lefort II or Lefort III – with bone graft   |
| D7950    | Osseous, osteoperiosteal or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report |
| D7953    | Bone replacement graft for ridge preservation – per site  |
| D7955    | Repair of maxillofacial soft and/or hard tissue defect  |
| D7995    | Synthetic graft – mandible or facial bones, by report   |
| D7996    | Implant-mandible for augmentation purposes (excluding alveolar ridge), by report                                |
| D7997    | Appliance removal (not by dentist who placed appliance), includes removal of archbar                            |

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## Description of Services

Orthognathic surgery is the surgical correction of skeletal abnormalities of the mandible (lower jaw), maxilla (upper jaw) or both. These abnormalities may be recognized at or shortly after birth (Congenital Defect) or may not become apparent until the individual grows and develops. The abnormalities may also be the result of traumatic injuries or secondary to systemic diseases. The primary goal of treatment is to improve facial form and function by correcting the skeletal abnormality. Often the severity of these abnormalities necessitates surgical correction in combination with other rehabilitative and non-surgical therapies including orthodontics. (AAOMS, 2020)

## Benefit Considerations

Reconstructive and medically necessary upper and lower jawbone surgery, orthognathic surgery, and jaw alignment may be covered when there is a facial skeletal abnormality and associated functional medical impairment. Refer to the member's specific benefit plan document for details.

## Clinical Evidence

In a 2023 systematic review and meta-analysis, Bunpu et al. assessed the masticatory function in patients before and following orthognathic surgery, and compared it to normal occlusion, and orthodontic treatment alone. Twenty one studies (11 cohort studies and 10 before- after studies) that met the inclusion criteria were included in the qualitative synthesis, and 17 were included in the meta-analysis. There were 1238 patients included and the follow-up period ranged from 2 weeks to 5 years. Outcomes measured were divided into three groups: (1) the results from the comminution method (any test in which the test food is comminuted into smaller particles, and the particle sizes/ volumes are measured), (2) bite force and (3) occlusal contact area. The results showed that masticatory performance improves with orthognathic surgery but does not reach the same level as normal occlusion, and the severity of the skeletal deformity plays a significant role in the level of improvement. Masticatory performance in patients who underwent orthodontic treatment alone was significantly improved and reached the same level as in normal occlusion patients. The authors concluded that orthognathic surgery improves the level of masticatory function but may not reach that of a normal occlusion. Additional studies with longer term follow up and using subjective results are needed to validate these findings.

Mulier et al. (2021) conducted a systematic review to evaluate long-term stability of dental and dentolabial changes following combine orthodontic and orthognathic surgical treatment with a minimum follow-up period of 5 years. A total of 11 studies (2 randomized control trials and 9 retrospective) with a postoperative follow-up conducted from 5 to 15 years. Quality of evidence was limited due to retrospective design and small sample size of some of the studies. Despite these limitations, the length of follow-up and detailed review of dental changes were considered strengths. Long-term changes were evaluated for overjet, overbite, maxillary, and mandibular incisor position and relationship of lip position to maxillary and mandibular incisors. The authors concluded that the current evidence suggests variability of dental and dentolabial

stability in both skeletal class II and III patients. Recommendations include further prospective studies to develop guidelines for long-term follow-up assessment using computer tomography or cone-beam computed tomography imaging before a final conclusion can be determined.

Wei et al. (2018) conducted a systematic review of the literature to compare the difference in postoperative stability between a surgery first/early orthognathic approach (SFEA) and a conventional orthodontics-first approach (COA). A total of 12 observational studies met the inclusion criterion with a total of 498 participants. The studies were published from 2010 to 2017. Of the studies reviewed, 7 studies used the Le Fort I osteotomy and bilateral sagittal split osteotomy (BSSO), 4 studies uses BSSO alone and 1 study used the Le Fort I osteotomy and intraoral vertical ramus osteotomy (IVRO). In all studies, rigid or semi-rigid internal fixation to fix the bony segment was used. A limitation of the is review is that all studies were conducted retrospectively which makes control for the confounding factors difficult. The authors concluded that SFEA may yield poorer postoperative stability than COA, specifically the mandible tends to rotate counter-clockwise more in SFEA. Recommendations include careful consideration for patient screening, amount of surgical movement and method of operation and fixation when designing surgical plan. Additional long term and high-quality prospective studies specific to evaluating postoperative stability of the SFEA are needed to evaluate these findings.

Haas Junior et al. (2017) performed a systemic review of the literature on the stability and surgical complications of segmental Le Fort I osteotomy. A total of 599 titles/abstracts possibility related were identified. The inclusion criteria included intervention study, analysis of stability and/or complications after maxillary osteotomy. Exclusion criteria included case reports, review of the literature and patient samples. A total of twenty-three studies were included: 14 evaluating stability as the outcome and 9 evaluating surgical complications. The studies were mostly retrospective (three used prospective design) and published over a 25-year period (1991 - 2016). These studies included a total of 2594 patients, primarily women, with an age range of 19.5 to 28.5 years. The selected studies that addressed outcome measure of stability were organized by stratifying surgical movement outcomes in the sagittal, vertical and transverse planes. In the authors analysis of these outcomes, instability is greater in terms of dental movement than in skeletal movement was inferred, which implies that preoperative and postoperative orthodontic treatment are the main factor of recurrence after maxillary expansion and heightened by the fact that the main goal of such combined orthodontic-surgical treatment is to correct crossbite. In this systematic review, surgical complications were also analyzed. Nine studies evaluated this outcome in a sample of 2078 patients. Overall, only 177 patients (8.5%) experienced a complication. The authors believe that the retrospective design of the included studies may lead to; an underestimation but the prevalence of complication is actually overestimated because of the convenience sampling strategy that included studies reporting surgical complications only. The authors concluded that the risk of complications after segmental Le Fort I osteotomy is in face lower than 8.5%. Limitations of this systematic review included: inclusion of non-peer-reviewed literature and conclusion relying primarily on observational studies.

Yang et al. (2017) performed a systematic literature review and meta-analysis of published comparative studies on the stability, efficacy, and surgical results of the surgery-first approach (SFA) versus conventional 3-stage method (CTM) orthognathic surgery. Ten nonrandomized controlled studies with a total of 513 patients met the inclusion criteria. These studies were published from 2010 to 2016. The outcomes consisted of treatment duration, postoperative stability, surgical movement and postoperative occlusion. The primary limitation is that only 10 nonrandomized studies were included; this small sample and non-randomization could increase the risk of bias. The findings indicate that patients in the SFA group benefited from shorter total treatment duration (weighted mean difference [WMD], -5.25; 95% confidence interval [CI], -8.21 to -2.29;  $p = .0005$ ), similar postoperative stability of the mandible (WMD, 0.35 mm; 95% CI, -0.24 to 0.94;  $p = .55$ ) and maxilla (WMD, 0.13 mm; 95% CI, -0.35 to 0.60;  $p = .60$ ), similar surgical movements, and other surgical results. The authors concluded that SFA is an efficient alternative to CTM with a shorter total treatment duration, similar postoperative stability, and other surgical results but had longer postoperative time in orthodontics.

Abrahamsson et al. (2015) conducted a study of 121 patients (treatment group) to investigate the self-estimated masticatory ability and performance in patients with dentofacial deformities before and after orthognathic treatment (including surgery) in comparison to an age and gender match control group. The sample included 98 patients (81%) that met the inclusion criteria and comprised of 38 males and 60 females with a mean age  $22.4 \pm 7.5$  years. After 18 months of treatment, 98 patients (81%) were assessed at follow-up examination for masticatory ability assessed on a visual analog scale and for masticatory performance evaluated by a masticatory test using round silicon tablets. Clinical examination and a questionnaire captured any signs and symptoms of temporomandibular disorders (TMD). There were 56 age and gender match subjects in the control group who were examined at baseline. The investigators concluded that patients with dentofacial deformities that were corrected by orthognathic surgery had a significant positive treatment outcome in respect of masticatory ability and masticatory performance; the severity of overall symptoms of TMD and the number of occlusal contacts influenced both the masticatory ability and performance; and that open bite had a negative effect on masticatory performance. Limitations of this study included lack of randomization and lack of longitudinal data on the control participants.

## Clinical Practice Guidelines

### *American Association of Oral and Maxillofacial Surgeons (AAOMS)*

Clinical practice guidelines have been published by AAOMS on criteria for orthognathic surgery (2020). The guidelines state that surgery may be indicated and medically necessary for:

- Anteroposterior discrepancies: established norm = 2mm
  - Maxillary/mandibular incisor relationship
    - Horizontal overjet of + 5mm or more
    - Horizontal overjet of zero to a negative value
  - Maxillary/mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm)
  - These values represent two or more standard deviation from published norms
- Vertical discrepancies
  - Presence of a vertical facial skeletal deformity, which is two or more standard deviations from published norms for accepted skeletal landmarks
  - Open bite
    - No vertical overlap of anterior teeth
    - Unilateral or bilateral posterior open bite greater than 2mm
  - Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
  - Supraeruption of a dentoalveolar segment due to lack of occlusion
- Transverse discrepancies
  - Presence of a transverse skeletal discrepancy, which is two or more standard deviations from published norms
  - Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth
- Asymmetries
  - Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry

These indications provide verifiable clinical measurements to significant facial skeletal deformities, maxillary and/or mandibular facial skeletal deformities associated with masticatory malocclusion. In addition to these conditions, orthognathic surgery may be indicated in cases where there are specific documented signs of dysfunction which may include airway dysfunction (e.g., sleep apnea), temporomandibular joint disorders, psychosocial disorders and speech disorders.

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage. Orthognathic surgery is a procedure and, therefore, not subject to regulation by the FDA.

## References

Abrahamsson C, Henrikson T, Bondemark L, et al. Masticatory function in patients with dentofacial deformities before and after orthognathic treatment—a prospective, longitudinal, and controlled study. *Eur J Orthod.* 2015 Feb;37(1):67-72.

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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.

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Wei H, Liu Z, Zang J, Wang X. Surgery-first/early-orthognathic approach may yield poorer postoperative stability than conventional orthodontics-first approach: a systematic review and meta-analysis. *Oral Surg Oral Med Oral Pathol Oral Radiol.* 2018 Aug;126(2):107-116.

Yang L, Xiao YD, Liang YJ, et al. Does the Surgery-First Approach Produce Better Outcomes in Orthognathic Surgery? A Systematic Review and Meta-Analysis. *J Oral Maxillofac Surg.* 2017 Nov;75(11):2422-2429.

## Guideline History/Revision Information

| Date       | Summary of Changes   |
|------------|--|
| 06/01/2024 | <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"><li>Revised coverage criteria; replaced criterion requiring:<ul style="list-style-type: none"><li>“Individual must have masticatory (<i>chewing</i>) and swallowing dysfunction due to skeletal malocclusion (e.g., inability to <i>incise</i> and/or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition)” with “individual must have masticatory and swallowing dysfunction due to skeletal malocclusion (e.g., inability to <i>bite</i> and/or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition)”</li><li>“Individual must have documentation of <i>speech deficits to support existence of</i> speech impairment due to skeletal <i>malocclusion</i>” with “individual must have documentation of speech impairment due to <i>facial skeletal deformity</i>”</li></ul></li></ul> <p><b>Benefit Considerations</b></p> <ul style="list-style-type: none"><li>Revised language to indicate Reconstructive and medically necessary upper and lower jawbone surgery, orthognathic surgery, and jaw alignment may be covered when there is a facial skeletal abnormality and associated functional medical impairment; refer to the member specific benefit plan document for details</li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, and <i>References</i> sections to reflect the most current information</li><li>Archived previous policy version MMG095.S</li></ul> |

## Instructions for Use

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual<sup>®</sup> criteria, to assist us in administering health benefits. UnitedHealthcare West Medical Management Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.