Connecticut Medical Assistance Program
Policy Transmittal 2016-30

Provider Bulletin 2016-73
November 2016

Roderick L. Bremby, Commissioner

Effective Date: December 1, 2016
Contact: Donna Balaski @ 860-424-5342

TO: Oral and Maxillofacial Surgeons, Hospital – Based Dental Clinics
RE: Clarification of Orthognathic Surgery Medical Necessity Definitions - Surgery Codes

The purpose of this policy transmittal is to give important information to oral and maxillofacial surgeons regarding the medical necessity requirements for orthognathic surgical procedures for specified oral and maxillofacial surgery codes. This change will take effect for dates of service on **December 1, 2016** and forward.

The codes subjected to prior authorization are listed on the current dental fee schedule which can be accessed on www.ctdssmap.com.

Orthognathic surgery is not a covered benefit when:

1. The procedure is cosmetic and **not medically necessary** when intended to change a physical appearance that would be considered within normal human anatomic variation.

2. The procedure is performed to correct malocclusion when the listed deviations from normal variations are not met.

3. The member has obstructive sleep apnea but other non – invasive modalities of treatment have not been tried; and

4. The member is not undergoing active orthodontic treatment.

Criteria of medical necessity for severe handicapping malocclusion

The presence of any of the following facial skeletal deformities associated with masticatory malocclusion after undergoing corrective orthodontics, will be considered on a case –by–case basis:

1. Congenital or traumatic anomalies that meet the criteria for reconstruction depending on the member's age, stage 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;; and
    e. Traumatic events

The member is undergoing active orthodontic treatment and meets the defined criteria of medical necessity for severe handicapping malocclusion where the malocclusion cannot be solely corrected through orthodontic treatment.

2. Anteroposterior discrepancies are defined as:

    a. Maxillary/Mandibular incisor relationship
    b. Overjet of 5mm or greater or a negative value
    c. Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or greater.

3. Transverse discrepancies are defined as:
    a. A unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth; or
    b. Complete bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater.

4. Vertical discrepancies are defined as follows:
    a. The presence of a vertical facial skeletal deformity which is two 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.

5. Asymmetries are defined as antero-posterior transverse or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry.

In addition to meeting the skeletal deformity requirement, the patient must also have one or more of the following functional impairments:

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).

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.

Sleep apnea caused by airway obstruction is defined as the moderate to severe obstructive 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:

a. Moderate for AHI or RDI ≥ 15 and ≤ 30; or
b. Severe for AHI or RDI > 30/hr;
c. Documentation of hypopharangeal obstruction; and
d. Conservative treatment measures have failed.
e. Difficulty swallowing is determined by the following conditions:
Significant weight loss and/or failure to thrive documented in the records over 4 months; or
Low Body Mass Index (<20); or
Low serum albumin related to malnutrition.

Submission of Prior Authorization Requests

All services that are treated in the operating room environment or require an overnight hospital admission must be reviewed and approved by the Department's medical administration service organization, Community Health Network of Connecticut.

Documentation required for review of all surgical cases includes but is not limited to: diagnostic and predictive imaging, including cephalometric tracings where applicable; a thorough description of the anomalies including a detailed description of all functional impairments; supporting diagnostic testing; facial photographs that are properly orientated and the quantification of the planned surgical movement(s).

Submit Prior Authorization (PA) requests to Community Health Network of Connecticut by fax at 203-265-3994.

Accessing the Fee Schedules

There are two dental fee schedules posted to the Connecticut Medical Assistance Program (CMAP) Web site; one for the pediatric reimbursement rates and the second for the adult reimbursement rates. The fee schedule may be accessed at www.ctdssmap.com; from this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I accept" button and proceed to click on the appropriate "Dental" fee schedule (adult or pediatric). To access the CSV file, press the control key while clicking the CSV link, then select "Open". The Connecticut Dental Health Partnership (CTDHP) has placed a copy of each of the Department's fee schedules on the www.ctdhp.com website.

For questions about billing or if further assistance is needed to access the fee schedule on the CMAP Web site, please contact the Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Posting Instructions: Policy transmittals can be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com

Distribution: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by Hewlett Packard Enterprise Services.

Responsible Unit: Department of Social Services, Health Services, Division of Integrated Services, Dental Unit, Donna Balaski, D.M.D. at (860) 424-5342 or donna.balaski@ct.gov

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