KAISER PERMANENTE® Northwest Region Utilization Review

UR 69: Orthognathic Surgery Medical Necessity Criteria

Department: Non-Behavioral Health Section: KPNW Region Applies to: KPNW Region Review Responsibility: Kelly Dezura, DMD; Alexis Kleinman, DMD	Number: UR 69 Effective: 01/2017 Last Reviewed: 3/21, 3/22, 5/23, 5/24, 4/25 Last Reviewed/Revised: 4/20

ORTHOGNATHIC SURGERY MEDICAL NECESSITY CRITERIA

Medical necessity criteria and policy are applied only after member eligibility and benefit coverage is determined. Questions concerning member eligibility and benefit coverage need to be directed to Membership Services.

PURPOSE

The purpose of these criteria is to define KFHPNW coverage for orthognathic surgery to treat a limited number of medical conditions, as mandated by WAC 284-43-5640.

DEFINITIONS

Orthognathic Surgery- the surgical correction of abnormalities of the mandible and/or maxilla. 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.

Malocclusion- imperfect positioning of the teeth when the jaws are closed. The condition may also be referred to as an irregular bite, crossbite, or overbite.

Congenital- a condition present at birth such as a cleft lip or cleft palate.

Coverage Guidance: Orthognathic surgery may be excluded from coverage. Check CM for exclusions or limitations.

Source	Policy
For Medicare Members	
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None
Kaiser Permanente Medical Policy for Medicare Members	UR 69 applies. Due to the absence of an NCD or LCD, Kaiser Permanente has chosen to use their own Clinical Review Criteria, "Orthognathic Surgery" for medical necessity determinations. Use the criteria below.

For Medicaid Members	
OR Medicaid	UR 69 does not apply. Check Linefinder
WA Medicaid	UR 69 does not apply
Commercial and Self-Funded Members	
OR Commercial	UR 69 applies
WA Commercial	UR 69 applies
Self-Funded Plans	UR 69 applies

CRITERIA

Orthognathic surgery and supplies are covered for any of the following:

1) conditions resulting from a skeletal malocclusion which resulted from TMJ arthritis, ankylosis, trauma or tumor and is not amenable to orthodontic therapy alone.

2) sleep apnea with a referral from a Sleep Medicine specialist. Patient must have documented severe OSA (obstructive sleep apnea) or the patient has documented mild-moderate OSA with severe symptoms (based on Epworth Sleepiness Scale) with an identifiable dentofacial deformity such as maxillary or mandibular hypoplasia. Patient is also either intolerant or unable to use CPAP.

3) a congenital anomaly that is not amenable to orthodontic therapy alone with a referral from a cranio-facial specialist (e.g. ENT, Cranio-facial Surgeon, Oromaxillo-facial Surgeon).

SPECIAL GROUP CONSIDERATIONS

Although this is a WA State mandate, the coverage criteria will be universally applied to all lines of business beginning 1/1/17 except as follows:

Added Choice/POS: members may directly access non-KP providers under their Tier 2 and Tier 3 benefits, without prior-authorization, for office visits that do not include a procedure. Procedures and levels of care other than office visits require prior-authorization.

REFERENCES

WAC 284-43-5640; Essential health benefit categories, section (3)b,iii,B