Medical Necessity Documentation for Orthognathic Surgery

Criteria established by the American Association of Oral and Maxillofacial Surgeons (AAOMS)

FOR REVIEWER USE ONLY:

1. Is there a DPHHS approved Orthodontia treatment plan, enter member ID in MMIS subsection #14 to find a PA#_____
2. Review/Print images in MAE under claim images using PA# as ICN
3. DPHHS Prior Authorization Form attached?_____
4. Coordination between Surgeon and Orthodontist, dates, etc._____

The Oral Surgeon must demonstrate the relationship between facial skeletal deformities and masticatory dysfunction, as well as the limitations of non-surgical therapies to correct these discrepancies. Submit the measurement of these discrepancies considering the dental compensations relating to the malocclusion and the underlying skeletal deformity.

Orthognathic surgery should be considered medically appropriate in the following circumstances.

Use the following forms to document your findings for prior authorization, in addition to the Medical-Surgical Prior Authorization Request Form. Fill in all areas that apply to this case.

1. ***Criteria for Orthognathic Surgery***, use to summarize the data on a single form.
2. ***Orthognathic Clinical Evaluation***, use to help gather the information to document the orthognathic criteria.
3. ***Orthognathic Surgical Planning***, use to quantify movement in preparation for orthognathic surgery.

To reference the full clinical paper as written by the AAOMS go to:
https://www.aaoms.org/docs/practice_resources/clinical_resources/ortho_criteria.pdf

NOTE:

- Separate prior authorization request is required for orthodontia services using the HLD-Index.
- Corrective jaw surgery is not used for cosmetic reasons.
- Future eligibility is not guaranteed and should be checked monthly.

Criteria for Orthognathic Surgery

PATIENT NAME:_____DIAGNOSIS:_____COMPLETED BY DR._____DATE COMPLETED:_____

A. ANTEROPOSTERIOR DISCREPANCIES

1. Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm). Yes/No_____
2. Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm) Yes/No_____
3. These values represent two or more standard deviation from published norms. Yes/No__

B. VERTICAL DISCREPANCIES

1. Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks.

   Yes/No_____
2. Open Bite
   a. No vertical overlap of anterior teeth.
   b. Unilateral or bilateral posterior open bite greater than 2mm. Yes/No_____
3. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch. Yes/No____
4. Supraeruption of a dentoalveolar segment due to lack of occlusion. Yes/No_____

C. TRANSVERSE DISCREPANCIES

1. Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms. Yes/No__
2. 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.

   Yes/No_____

D. ASYMMETRIES

1. Anteroposterior, transverse or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry. In addition to the above conditions, orthognathic surgery may be indicated in cases where there are specific documented signs of dysfunction. These may include conditions involving airway dysfunction such as sleep apnea, temporomandibular joint disorders, psychosocial disorders and or speech impairments.

   Yes/No_____

Orthognathic Surgery Clinical Evaluation

Name: **Diagnosis:** **Date:**

DENTAL FACIAL EVALUATION: FRONTAL VIEW

Vertical facial eval.

Interlabial distance:_____mm (lip incompetence)

Lip tooth relationship:

*Repose (1.5-3.5mm tooth show):_____mm

*Smile (#7-10, 8-12mm tooth show):_____mm

_____mm gingival show

Upper lip length (_22+/-2,_20+/-2mm):_____mm

Labiomental fold: Norm Deep Flat

Nasal evaluation

Nasal airway:

*Cottle: Right ❒+ ❒ - left ❒ + ❒-

*Septum: ❒ deviated R L

*Turbinates: ❒ normal ❒ Large

Nasal ecaluation:

*Tip: ❒ wnl *Dorsum: ❒wnl

* Nasolabial angle:_____

*Alar base (width):_____mm

❒narrow ❒WNL ❒wide

Transverse facial eval.

Midlines relative to midsagittal plane.

Facial midline (asymmetry): ❒wnl

Nasal dorsum midline: ❒ wnl

Dental midline:

*Upper: R_____C_____L_____

*Lower: R C L

Chin midline: R C L

Occlusal Cant: ❒ none

Facial evaluation

Midface: ❒ flat ❒ wnl ❒ prominent

* infraorbital soft tissue relative to globe:

❒posterior ❒in line ❒ anterior

Zygoma: ❒ wnl

Orbit:

*Eye Lid's: ❒ wnl

*Brow: ❒ wnl

Facial Proportions:

*Upper 1/3:

*Middle 1/3:

*Lower 1/3:

LATERAL VIEW

Profile eval.

Facial Profile: Convex Concave Flat

Cervicomental angle: ❒ acute (< 90 degrees) ❒ obtuse (>90 degrees)

Glabella Vertical:

*Maxilla: ❒ deficient ❒ normal ❒ excessive

*Mandible: ❒ deficient ❒normal ❒ excessive

ORAL EXAM

Molar: I II III Canine: I II III

Curve of Wilson (molar tipping): no yes

Curve of Spee: ❒ flat ❒ wnl ❒ excessive

H-Overjet: mm V-Overbite:_____mm

Ant Open bite: mm post Cross Bite: y n

Missing teeth:

3rd Molars: ❒ missing

Active Periodontal disease: NO YES

Attached Gingiva: ❒ wnl Pathology: ❒ none

Airway obstruction: N Y Apnea: N Y

TMJ EXAM

Symptoms: NO YES:_____

_____

_____

Preauricular: NTP R

_____L_____ Muscles:

NTP R_____ L_____

Click/Pop: NO YES

*Open: R_____L_____

*Close: R_____L_____

MIO:_____

ROM: L_____R_____Protrusive_____

Deviation: NO R_____ L_____

Orthognathic Surgical Planning

Planned three dimensional surgical movements and soft tissue modifications:

Patient Name: **Diagnosis:** **Surgery Date:**

A) Maxilla: ☐ No procedure ☐ Lefort I osteotomy

1. Vertical impaction:
   - ☐ Posterior to correct open bite: ☐ RIGHT:_____mm ☐ LEFT:_____mm
   - ☐ Total impaction correct VME: ☐ RIGHT:_____mm ☐ LEFT:_____mm
2. Horizontal advancement (A-P):_____mm anterior
3. Rotation for midline correction: ☐ Right_____mm ☐ Left_____mm
4. Maxillary segmental surgery: ☐ no ☐ yes:
   - ☐ Two piece-interdental Osteotomies between: #_____& #_____
   - ➢ Is their adequate space between the teeth radiographically to perform the interdental Osteotomies? Yes No
   - ☐ Three piece-interdental Osteotomies between: #_____& #____+ #_____& #_____
   - ➢ Is their adequate space between the teeth radiographically to perform the interdental Osteotomies? Yes No
5. Horizontal Osteotomy:
   - ☐ Conventional.
   - ☐ High (for augmentation of midface deficiency).
     - ☐ Stepped with or without intermediate bone graft in the maxillary buttress. (For advancement of the maxilla greater than 5mm and for enhanced satiability and OSAS surgery).
6. Other considerations:

B) Mandible: ☐ No procedure ☐ BSSO ☐ IVRO ☐ other:

1. Horizontal: ☐ Advancement_____mm ☐ Setback_____mm
2. Rotation: ☐ Right_____mm ☐ Left_____mm
3. Genioplasty: ☐ no ☐ yes:
   - ☐ Advancement_____mm ☐ Setback_____mm
   - ☐ Vertical reduction_____mm ☐ Right ☐ Left ☐ Bilateral
   - ☐ Vertical augmentation_____mm ☐ Right ☐ Left ☐ Bilateral
   - ☐ Rotation_____mm ☐ Left ☐ Right
4. Other considerations:

C) Occlusion:

1. Enameloplasty: ☐ no ☐ yes:
   - #
   - #
   - #
2. Extractions: ☐ no ☐ yes:
   - #(s)

D) Nasal:

1. Alar Cinch: ☐ no ☐ yes:
2. Turbinectomy: ☐ no ☐ yes:
3. Septoplasty: ☐ no ☐ yes:

E) Other considerations: