APPENDIX to Orthognathic Surgery Policy

Prior Authorization Requirements

Clinical Evidence is required to determine **medical necessity**.

Within five days before the actual date of service, the Provider MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

Evidence Basis for the Policy

Rationale

It is estimated that 1.5-2 million individuals in the United States with developmental dentofacial deformities may benefit from orthognathic surgery. The underlying deformity may be present at birth, may become evident as an individual grows and develops, or may be the result of traumatic injury or disease. Dentofacial skeletal anomalies normally occur as a result of a differential growth of the upper facial skeleton to the lower facial skeleton which produces a discrepancy of the normal relationship of the upper and lower jaw. Genetic predisposition and acquired causes may also influence the growth of the facial skeleton. Various congenital disorders such as Apert and Crouzon syndromes and oral-facial clefts affect normal growth and development. Traumatic events to the facial skeleton can displace normal elements and disturb normal subsequent growth. Tumors, surgical resections, and iatrogenic radiation can also result in dentofacial abnormalities.

Orthognathic surgery involves the surgical manipulation of the facial skeleton, particularly the maxilla and mandible, to restore the proper anatomic and functional relationship in patients with dentofacial skeletal anomalies. Examples of conditions for which orthognathic surgery is used include mandibular prognathism, crossbite, open bite, overbite, underbite, mandibular deformity, and maxillary deformity. Orthognathic surgery may also be referred to as jaw surgery, dentofacial skeletal surgery, craniofacial surgery or facial orthopedic surgery. These procedures include osteotomy, ostectomy, or osteoplasty, and the insertion of plates, screws, and wires to hold bones together. Several surgical methods may be used depending on the severity of the deformity. Additionally, orthodontic therapy (braces) may be required preoperatively and postoperatively.

Diagnostic Workup

The diagnostic workup normally includes a comprehensive assessment and documentation of history and clinical examination including the description of the anatomic deformity and symptoms, skeletal evaluation with radiographs, photographs that demonstrate the facial asymmetry or dental occlusion, and dental evaluation with study dental casts.

There are three main categories that maxillofacial deformities are divided into: dental dysplasias, skeletal dysplasias, and dentoskeletal dysplasias.

- Dental dysplasias are normally limited to malocclusions that have resulted from abnormal spatial relationships of the dentition and not from the skeletal position of the upper and lower jaws. These malocclusions can normally be managed by orthodontia.
- Skeletal dysplasias have dentition that is in good alignment however, the maxilla and/or the mandible are dysplastic (abnormally developed). In these cases, the skeletal dysplasia requires correction of the skeletal deformity without altering the occlusion.
- Dentoskeletal dysplasias have dentition that is malpositioned within each arch and with each other. In addition, the skeletal relationship of the upper and lower jaws is abnormal. Correction requires aligning the dentition within each arch with orthodontic treatment and then restoring the maxillary-mandibular dental relationship with skeletal osteotomies and repositioning.

Additionally, dentoskeletal dysplasia can be further classified based on the position in space and on the volume or mass (whether deficient or in excess) of the individual elements. Skeletal facial anomalies are referenced as spatial planes of horizontal, vertical, transverse, or in combination. These provide verifiable clinical measurements to determine significant facial skeletal deformities.

The American Association of Oral and Maxillofacial Surgeons (AAOMS 1988) classified dentofacial deformities as mid-face or mandibular, as follows:

Skeletal deformities of the midface

- Maxillary hyperplasia
- Maxillary hypoplasia
- Cleft deformities
- Other midface deformities, including nasal, zygomatic, orbital, ethmoidal, frontal or other cranial bones

Skeletal deformities of the mandible

- Mandibular hyperplasia
- Mandibular hypoplasia
- Mandibular asymmetry
- Condylar abnormalities, including hypoplasias, hyperplasia, neoplasia, ankylosis, post-traumatic conditions, and agenesis

In addition, the following classifications or terms may be documented:

Dental occlusal classification

The classification of dental occlusions is based on Edward Angle's observation that the key to occlusion is the relationship of the mandibular first molar to the maxillary first molar.

Class I (neutro-occlusion): The mesiobuccal cusp of maxillary first molar articulates within the mesiobuccal groove of the mandibular first molar. The molar relationship of the occlusion is normal; but the other teeth have problems like spacing, crowding, over or under eruption, etc.

Class II (disto-occlusion): The mandibular first molar articulates distal to the mesiobuccal cusp of the maxillary first molar. These malocclusions have a tendency toward a deep bite or "overbite."

The malocclusion may be due to deficiency of the lower jaw or excess of the upper jaw. It is further classified into two subtypes:

- Class II Division 1: the mandibular arch is behind the upper jaw with protrusion of the upper front teeth
- Class II Division 2: the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth

Class III (mesio-occlusion): The mesiobuccal groove of the mandibular first molar is mesial to the mesiobuccal cusp of the maxillary first molar. This is when the lower front teeth are more prominent than the upper front teeth. Also known as prognathism, "underbite", or "negative overjet." This type of occlusion usually produces a strong or protrusive chin, which may be due to either horizontal mandibular excess or horizontal maxillary deficiency.

The Angle classification only relates to maxillary dentition with the mandibular dentition. While it is generally assumed that a similar skeletal relationship of Class I, II, and III follows, this is not always the situation. For example, a Class I molar relationship is possible with a Class II skeletal relationship by dental extractions and orthodontic alignment without regard to basal skeletal morphology.

Upper and lower arch dentition

These terms are used to describe the relationship between the dentition of the upper and lower arches.

- Overjet: The horizontal distance between the incisal edges of the maxillary incisor to the mandibular incisor.
- Overbite: The vertical distance between the incisal edge of the maxillary incisor and the mandibular incisor.
- Crossbite: The lingual-buccal malposition of the normal relationship between the upper and lower dentition (negative overjet).
- Deep bite: The condition of excessive overbite.
- Open bite: The condition of negative overbite (teeth do not meet).

Imaging Studies

- Cephalometric x-rays: Standardized skull and/or facial views that allow for comparison over time to assess growth in an individual and for comparison of that individual against standardized population norms.
- Ortho-Panorex x-rays: Films that provides an overview of the stage of dental development, the mandibular anatomy, and gross pathology. Specific films such as occlusal and periapical views can be obtained to further assess the dentition, supporting bone, and interdental spaces.
- Periapical films: Obtained to determine if sufficient space exists for interdental osteotomies.
- Three dimensional computerized tomography (3D CT): 3D CT is increasingly being used for surgical evaluation and planning in academic university settings. However, in the future, this 3D visualization of the anatomic deformity may likely replace conventional two-dimensional cephalometric analysis.
- Long bone x-rays: Hand wrist films are useful in determining skeletal age based on the known timing of sequential closure of the epiphyseal growth plates. Typically, facial skeletal maturity is determined by comparison of serial lateral cephalometric films obtained at 6 month intervals.

The American Association of Oral and Maxillofacial Surgeons' criterion for Orthognathic Surgery (2008) has become an accepted assessment tool to determine if orthognathic surgery is medically necessary. This tool provides verifiable clinical measurements of maxillary and/or mandibular facial skeletal deformities associated with masticatory malocclusion and advises the following criteria:

A. Anteroposterior discrepancies

- Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm).
- 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.

B. 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.

C. 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.

D. Asymmetries

- Anteroposterior, transverse or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry.

Additionally, interpretation of cephalometric radiographic landmarks, points and planes can be assessed to determine medical necessity. Standard cephalometric films are traced and various standard landmarks, lines and angles are measured and recorded. This allows for comparison with normal values for a population and assessment of growth and/or effects of treatment. A widely used analysis used by orthodontics is the Eastman Analysis' (Harris et al., 1991). Key landmarks are identified such as the Sella (S), the nasion (N), the (A) point (position of deepest concavity on the anterior profile of the maxilla), and the (B) point (position of deepest concavity on anterior profile to the mandibular symphysis). Angular measurements including SNA/SNB/ANB angles are evaluated. If the SNA or SNB values are greater or less than normal this indicates that the mandible or maxilla is positioned either anteriorly or posteriorly and may reflect a difference in jaw growth and size. ANB indicates the relative position of the maxilla to the mandible, and allows the measurement of the extent of the jaw size and position discrepancy (Stuani et al., 2000). Further reference to these values is included in the Policy Guideline. Computerized generated prediction tracings may be utilized to reflect the skeletal abnormalities for diagnosis, preoperative planning, and postoperative evaluation.

According to the AAOMS (2008) there is convincing evidence of the relationship between facial skeletal abnormalities and malocclusions, including Class II, Class III and openbite deformities. A strong correlation has been demonstrated between the state of the occlusion and chewing efficiency. They report that studies have shown that patients with skeletal malocclusions suffer from a variety of functional impairments including diminished bite forces, restricted mandibular excursions and abnormal chewing patterns. The authors further advised that orthognathic surgery has resulted in improvement of skeletal deformities that contribute to functional parameters of chewing, breathing and swallowing dysfunction when the deformity can not be corrected by dental therapeutics or orthodontics. The AAOMS conclusions were based on non-randomized controlled trials and case series studies.

The 2008 AAOMS criteria also discussed the following position on orthognathic surgery for facial skeletal discrepancies associated with documented speech impairments. “Abnormal jaw relationships affect many of the structures involved in the production of speech, including the position of the lips, tongue and soft palate. Studies demonstrate that altered speech production may be associated with facial skeletal deformities, the most common impairment of which is a distortion within the sibilant sound class. Such studies also demonstrate the beneficial effects of orthognathic surgery on speech production, documenting improvement in a high percentage of patients after the correction of abnormal jaw relationships. Prior to surgery, speech evaluation should be should be obtained to demonstrate the nature of the problem and determine if

improvement can be expected." A study by Janulewicz et al., (2004) confirmed previous findings that "patients with clefts of the lip and palate or palate alone are predisposed to velopharyngeal function alteration after maxillary advancement, particularly with borderline function preoperatively. However, these results show that surgical correction of skeletal relationships and occlusion may translate into improvement" in only certain aspects of speech disorders. Much of the literature regarding speech impairments has been done on cleft abnormalities in which orthognathic surgery would be considered reconstructive. However, there is inadequate evidence in the peer reviewed literature to support the effectiveness of orthognathic surgery for correction of articular disorders, and other impairments in the production of speech or speech quality.

Surgical Treatment Plan

Correction of maxillofacial deformities requires careful analysis of the soft tissue with clinical examination and supporting photographs, skeletal evaluation with standardized radiographs, and dental evaluation with dental molds or casts done in the initial diagnostic evaluation. Development of the treatment plan requires close cooperation of the surgeon working with the dentist, the orthodontist, and at times the restorative prosthodontist. Furthermore, when contemplating surgical intervention, it is important to determine whether to intervene prior to completion of skeletal growth or to await skeletal maturity to eliminate the variability of subsequent growth and the requirement for further surgical intervention.

Once the decision is made to undergo orthognathic surgery, the management can be divided into 5 phases (Patel, 2009):

- Preorthodontic preparatory phase
- Presurgical orthodontic treatment phase
- Surgical phase
- Postsurgical orthodontic phase
- Prosthodontic treatment phase

In the **preorthodontic prepatory phase**, periodontal disease and caries treatment is essential to reduce gingival inflammation along with cleaning and good oral hygiene. The decision as to whether endodontic treatment or extraction is required is also made at this time.

In the **presurgical orthodontic treatment phase** extraction may be performed or expansion of the arch may be a better choice to provide sufficient space to allow dentition to be placed within the supporting basal bone. In example, if a mandibular osteotomy is contemplated, extraction of the mandibular third molars may be required and is done typically 8-12 months prior. Orthodontia follows to align the dentition within the dental arch, level the curve of Spee, and decompensate the anterior dentition. Progressive dental models are made throughout the orthodontic treatment and dental casts can then confirm the readiness for surgery. The presurgical phase may vary from 6-18 months depending on what needs to be accomplished prior to surgery. Reevaluation of the patient with radiographic studies, analysis of presurgical cephalometric films and prediction tracings are accomplished approximately 2-3 weeks prior to a surgical date. A model surgery is performed to simulate the planned operative procedure. An acrylic splint is constructed which allows for accurate intraoperative positioning of the maxilla

and mandibular dentoalveolar segments. The surgeon chooses the type of mandibular surgery based on their experience, evaluation of photographic and cephalometric analysis, and the model surgery.

In the **surgical phase**, depending on the procedure, corrective jaw surgery may be performed under general anesthesia in a hospital, an ambulatory surgical center or in the oral and maxillofacial surgery office. Surgery may take from one to several hours to complete. In orthognathic surgery, an osteotomy is made in the affected jaw, and the bones are repositioned in a more physiologic alignment. In general, the bones are held in new positions with plates, screws and wires. Arch bars on both jaws may also be inserted to gain stability (intermaxillary fixation). If the deformities affect both jaws, coinciding or staged osteotomies may be performed to achieve correction. If there is deficient bone tissue, grafts from the patient's ribs, hips or skull may be taken and alloplastic replacement of missing bone may be required.

Most maxillofacial deformities can be managed with 3 basic osteotomies: the mid face with the Le Fort I-type osteotomy, the lower face with the sagittal split ramal osteotomy of the mandible, and the horizontal osteotomy of the symphysis of the chin. The choice of the procedure depends on the specific deformity. The LeFort I osteotomy allows correction primarily at the occlusal level affecting the upper lip position, nasal tip and alar base region, and the columella labial angle without altering the ortibozygomatic region. The LeFort II osteotomy allows alteration of the nasomaxillary projection without altering the orbital volume and zygomatic projection. Finally, the LeFort III osteotomy allows complete craniofacial dysfunction and alters the orbital position and volume, zygomatic projection, position of the nasal root, frontonasal angle, and position of the maxilla and lengthening of the nose. All of these osteotomies are frequently modified to address specific clinical situations. For the lower face, osteotomies are used to correct mandibular deformities. The sagittal split ramal osteotomy is the most commonly performed to correct mandibular prognathism (abnormal protrusion of the mandible) and retrognathism (mandible is located more posterior to the normal position). In extreme cases of mandibular prognathism, some surgeons prefer the intraoral vertical osteotomy or the inverted L-osteotomy. This may be done in conjunction with or separate from maxillary surgery. Combinations of procedures may again be necessary.

The chin may also be an important component of the facial profile as well as for aesthetic balance. Deformities of the chin may exist independently of mandibular deformities, or can be abnormally proportioned without occlusal involvement. Alloplastic chin implants are commonly used for chin deficiencies however, most craniofacial surgeons prefer the sliding horizontal osteotomy genioplasty because it is more versatile. The chin can be repositioned in multiple planes, allowing for correction of significant sagittal and vertical deformities of deficiency (microgenia) or excess (macrogenia) and asymmetric conditions. However, when chin implants or genioplasty procedures are performed in isolation, or for correction of unaesthetic facial features with other surgical procedures, may be considered cosmetic (Patel, 2009).

The **orthodontic phase** typically begins (if required) approximately 4-8 weeks post surgery. The patient at this point has been gradually returning to his/her normal diet. The remaining interdental spaces are closed and the dentition is brought to its maximum intercuspal relationship. This phase may take 4-6 months ending with removal of the orthodontic braces and

advancing to a retainer. Photographs, radiographic studies, and dental models, are obtained and then again one year post postoperatively.

The final phase, **prosthodontic treatment,** may include dental implants, prosthetic and periodontal treatment, and dental restoration for final dental esthetics (Patel, 2009).

Contraindications or risk factors may alter the treatment plan or preclude surgery and include, but are not limited to, underlying medical conditions, bleeding dyscrasias, systemic disease or factors that may affect normal wound healing, compromised vascularity of the surgical region, a patient with unrealistic expectations, non-compliant patients, and patients with poor oral hygiene. As with any other surgery, there can be some complications such as bleeding, swelling, infection, nausea and vomiting. Nerve damage from injury to the infraorbital, inferior alveolar or mental nerves may occur and cause numbness which can be temporary or rarely, permanent (Patel, 2009). Infection, malunion and/or non-union, and injury to teeth may occur but in general these complications are not frequent.

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program (FEP)) prohibit Plans from denying Food and Drug Administration (FDA) - approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

Type	Number	Description
CPT	21085	Impression and custom preparation; oral surgical splint
	21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	Genioplasty; sliding osteotomy, single piece

Type	Number	Description
	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, 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 (eg, 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) (eg, ungrafted unilateral alveolar cleft)
	21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
	21150	Reconstruction midface, LeFort II; anterior intrusion (eg, 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
	21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I

Type	Number	Description
	21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
	21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, 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 graft (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 (eg, Wassmund or Schuchard)
	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
	21209	Osteoplasty, facial bones; reduction
	21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
	21215	Graft, bone; mandible (includes obtaining graft)
	21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
	21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
HCPC	D7940	Osteoplasty, for orthognathic deformities
	D7941	Osteotomy - mandibular rami

Type	Number	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
	D7995	Synthetic graft, mandible or facial bones, by report
	D7996	Implant, mandible for augmentation purposes (excluding alveolar ridge), by report
ICD9 Procedure	76.43	Other reconstruction of mandible
	76.46	Other reconstruction of other facial bone
	76.61	Closed osteoplasty (osteotomy) of mandibular ramus
	76.62	Open osteoplasty (osteotomy) of mandibular ramus
	76.63	Osteoplasty (osteotomy) of body of mandible
	76.64	Other orthognathic surgery on mandible
	76.65	Segmental osteoplasty (osteotomy) of maxilla
	76.66	Total osteoplasty (osteotomy) of maxilla
	76.67	Reduction genioplasty
	76.68	Augmentation genioplasty
	76.69	Other facial bone repair
	76.91	Bone graft to facial bone
	76.92	Insertion of synthetic implant in facial bone
ICD9 Diagnosis	All Diagnoses	

Type	Number	Description
Place of Service	All Places of Service	

Tables

N/A

Definitions

Alveolar or Alveolus: that portion of the upper and lower jaws that contain the teeth and form the dental arches

Anomaly: deviation from normal

Dysplasia: Abnormal tissue development

Genioplasty: plastic surgery of the chin; also called mentoplasty

Hyperplasia: overgrowth or enlargement

Mandible: lower jaw

Maxilla: upper jaw

Maxillary hyperplasia: Overgrowth of the maxilla, or upper jaw, often presenting as excess vertical height of the maxilla

Maxillary hypoplasia: an abnormally small or posteriorly positioned maxilla, or upper jaw, often accompanying cleft palate or other craniofacial syndromes

Micrognathia: an abnormally small mandible or lower jaw

Occlusal: In dentistry, pertaining to the contacting surfaces of opposing occlusal units (teeth or occlusion rims) or the masticating surfaces of the posterior teeth

Occlusion: the way the teeth bite or come together. Occlusions may be normal or abnormal (malocclusion) and are classified as Class I, Class II, or Class III

Malocclusion: imperfect contact with the mandibular and maxillary teeth

Orthodontics: the division dental specialty dealing with the prevention and correction of abnormally positioned or aligned teeth

Osteotomy: The incision, sectioning, or cutting of a bone, without removing any of its parts, for the purpose of repositioning it into a structurally correct location with itself and adjacent structures (bone cut)

Ostectomy: The excision, sectioning, or cutting of a bone for the purpose of removing a portion of the bone and repositioning it into a more structurally balanced relationship with itself and adjacent structures (bone removal)

Osteoplasty: A surgical procedure that is designed to change or modify the shape or configuration of a bone (bone graft)

Prosthodontics: the dental specialty concerned with the making of artificial replacements for missing parts of the mouth and jaw -- called also prosthetic dentistry, prosthodontia

Sibilant: consonant characterized by a hissing sound (like s or sh)

Velopharyngeal distortion: pertaining to the soft palate (velum palatinum) and the pharyngeal walls

Index / Cross Reference of Related BSC Medical Policies

The following Medical Policies share diagnoses and/or are equivalent BSC Medical Policies:

- Reconstructive Services
- Diagnosis and Treatment Services for Obstructive Sleep Apnea (OSA) and Upper Airway Resistance Syndrome (UARS)
- Arthroscopy and Arthroscopic Surgery of the Temporomandibular Joint (TMJ)

Key / Related Searchable Words

- Mandibular surgery
- Maxillary surgery

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Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action	Reason
4/3/2009	New Policy Adoption	Medical Policy Committee
4/2/2010	Administrative Update	Medical Policy Committee
9/29/2010	Policy revision with position change: clarification of reconstructive statement verbiage	Medical Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

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