

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		
<p>Interlabial distance: _____mm (lip incompetence)</p> <p>Lip tooth relationship:</p> <p>*Repose (1.5-3.5mm tooth show): _____mm</p> <p>*Smile (#7-10, 8-12mm tooth show): _____mm</p> <p>_____mm gingival show</p> <p>Upper lip length (_22+/-2, _20+/-2mm): _____mm</p> <p>Labiomental fold: Norm Deep Flat</p>	Vertical facial eval.	<p>Nasal airway:</p> <p>*Cottle: Right <input type="checkbox"/>+ <input type="checkbox"/>- left <input type="checkbox"/>+ <input type="checkbox"/>-</p> <p>*Septum: <input type="checkbox"/> deviated R L</p> <p>*Turbinates: <input type="checkbox"/> normal <input type="checkbox"/> Large</p> <p>Nasal ecaluation:</p> <p>*Tip: <input type="checkbox"/> wnl *Dorsum: <input type="checkbox"/> wnl</p> <p>* Nasolabial angle: _____</p> <p>*Alar base (width): _____mm</p> <p><input type="checkbox"/>narrow <input type="checkbox"/>WNL <input type="checkbox"/>wide</p>
<p><u>Midlines relative to midsagittal plane.</u></p> <p>Facial midline (asymmetry): <input type="checkbox"/> wnl</p> <p>Nasal dorsum midline: <input type="checkbox"/> wnl</p> <p>Dental midline:</p> <p>*Upper: R _____ C _____ L _____</p> <p>*Lower: R C L</p> <p>Chin midline: R C L</p> <p>Occlusal Cant: <input type="checkbox"/> none</p>	Transverse facial eval.	<p>Midface: <input type="checkbox"/> flat <input type="checkbox"/> wnl <input type="checkbox"/> prominent</p> <p>* infraorbital soft tissue relative to globe:</p> <p><input type="checkbox"/>posterior <input type="checkbox"/>in line <input type="checkbox"/> anterior</p> <p>Zygoma: <input type="checkbox"/> wnl</p> <p>Orbit:</p> <p>*Eye Lid's: <input type="checkbox"/> wnl</p> <p>*Brow: <input type="checkbox"/> wnl</p> <p>Facial Proportions:</p> <p>*Upper 1/3:</p> <p>*Middle 1/3:</p> <p>*Lower 1/3:</p>
LATERAL VIEW		
<p>Facial Profile: Convex Concave Flat</p> <p>Cervicomental angle: <input type="checkbox"/> acute (< 90 degrees) <input type="checkbox"/> obtuse (>90 degrees)</p> <p>Glabella Vertical:</p> <p>*Maxilla: <input type="checkbox"/> deficient <input type="checkbox"/> normal <input type="checkbox"/> excessive</p> <p>*Mandible: <input type="checkbox"/> deficient <input type="checkbox"/>normal <input type="checkbox"/> excessive</p>		Profile eval.
ORAL EXAM		TMJ EXAM
<p>Molar: I II III Canine: I II III</p> <p>Curve of Wilson (molar tipping): no yes</p> <p>Curve of Spee: <input type="checkbox"/> flat <input type="checkbox"/> wnl <input type="checkbox"/> excessive</p> <p>H-Overjet: mm V-Overbite: _____mm</p> <p>Ant Open bite: mm post Cross Bite: y n</p> <p>Missing teeth:</p> <p>3rd Molars: <input type="checkbox"/> missing</p> <p>Active Periodontal disease: NO YES</p> <p>Attached Gingiva: <input type="checkbox"/> wnl Pathology: <input type="checkbox"/> none</p> <p>Airway obstruction: N Y Apnea: N Y</p>		<p>Symptoms: NO YES: _____</p> <p>_____</p> <p>_____</p> <p>Preauricular: NTP R</p> <p>_____ L _____ Muscles:</p> <p>NTP R _____ L _____</p> <p>Click/Pop: NO YES</p> <p>*Open: R _____ L _____</p> <p>*Close: R _____ L _____</p> <p>MIO: _____</p> <p>ROM: L _____ R _____ Protrusive _____</p> <p>Deviation: NO R _____ L _____</p>

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. Turbectomy: ☐ no ☐ yes:

3. Septoplasty: ☐ no ☐ yes:

E) Other considerations: