Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required (Concurrent review may be required)	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404.
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.
In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan.

Clinical Guideline Coverage Criteria

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for Orthognathic Surgery for Severe Oral-Maxillofacial Disorders:

1. Bone Augmentation, Mandible
2. Bone Augmentation, Maxilla
3. Orthognathic Surgery
4. Orthognathic Surgery (Pediatric)

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes – Bone Augmentation, Mandible

Code	Description
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)

Table 2: CPT/HCPCS Codes – Bone Augmentation, Maxilla

Code	Description
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

Table 3: CPT/HCPCS Codes – Orthognathic Surgery

Code	Description
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
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)
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; three 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) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
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

Code	Description
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)
21215	Graft, bone; mandible (includes obtaining graft)
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21215	Graft, bone; mandible (includes obtaining graft)
21299	Unlisted craniofacial and maxillofacial procedure

Table 4: CPT/HCPCS Codes – Orthognathic Surgery (Pediatric)

Code	Description
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; three 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) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
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

Note: The following procedure(s) CPT and HCPCS codes require prior authorization and must meet the requirements of one of the InterQual SmartSheets or Subets listed above.

Table 5: CPT/HCPCS Codes – Additional Codes

Code	Description
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
D7940	Osteoplasty-for orthognathic deformities
D7941	Osteotomy-mandibular rami
D7943	Osteotomy-mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy-segmental or subapical
D7945	Osteotomy-body of mandible
D7946	LeFort I (maxilla-total)
D7947	LeFort I (maxilla-segmented)
D7950	Osseous, osteoperiosteal, or cartilage of the mandible or maxilla-autogenous or nonautogenous
D7993	Surgical placement of craniofacial implant - extra oral
D7994	Surgical placement: zygomatic implant
D7995	Synthetic graft-mandible or facial bones, by report
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report

Table 6: CPT/HCPCS Codes – Noncovered

Code	Description
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- November 24, 2020: Fax number for Unify updated
- February 4, 2021: Coding updated. Per AMA CPT®, effective January 1, 2021 the following code(s) added: D7993, D7994
- April 21, 2021: Reviewed at IMPAC. Code 21235 Graft, ear cartilage removed and no longer requires prior authorization with effective date of 5/15/2021.
- July 21, 2021: Reviewed at IMPAC. Coding updated per InterQual 2021 update; code 21193 and 21194 removed from Osteotomy, SAGITTAL SPLIT, Mandible Ramus procedure
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- February 1, 2022: Template Updated
- May 18, 2022: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Harvard Pilgrim Health Care with an effective date of October 1, 2022. Removed coding under the section “Temporomandibular Joint (TMJ) Disorder Treatment Medical Necessity Guidelines”; link to codes provided
- December 1, 2022: Reviewed by MPAC, renewed without changes
- June 21, 2023: reviewed by MPAC, renewed without changes
- September 20, 2023: reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- December 1, 2023: Reviewed and approved by the UM Committee effective January 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual upgrade, renewed without changes effective July 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update; adopted new InterQual subset for both adult and pediatric Orthognathic surgery; removed “Modifications to InterQual criteria for pediatric members less than 18 years of age”; removed codes D7948 and D7949 effective July 1, 2025
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- September 17, 2025: Reviewed by the UM Committee, renewed without changes effective October 1, 2025
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update and Annual Review; administrative update to guideline template; effective July 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.