BlueCross BlueShield Arizona | Health Choice

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BLUE CROSS BLUE SHIELD OF ARIZONA HEALTH CHOICE
DENTAL CLINICAL REVIEW CRITERIA

Department	**Utilization Management**
Policy Number	**D0010**
Subject	**Orthodontic Services and Orthognathic Surgery**
Attachments	**None**

Overview:

Blue Cross Blue Shield of Arizona Health Choice provides coverage for orthodontic services and orthognathic surgery for Medicaid EPSDT members ages 20 and younger when services meet the plan's medically necessary orthodontic treatment criteria. Coverage is provided when orthodontic treatment and/or orthognathic surgery are determined to be the primary treatment of choice or an essential component of an overall treatment plan developed by the primary care provider (PCP) in consultation with the treating orthodontist, dentist, or specialist.

This policy defines the orthodontic-specific criteria used by Blue Cross Blue Shield of Arizona Health Choice to determine medical necessity in accordance with AHCCCS EPSDT requirements, AHCCCS medical necessity standards, and applicable Arizona Administrative Code (AAC) provisions.

Definitions

Medically Necessary Orthodontic Treatment

Medically necessary orthodontic treatment refers to orthodontic care that is appropriate for correcting a severe, handicapping malocclusion. For the purposes of dental services, a condition is considered medically necessary when the absence of treatment would be expected to result in adverse effects on the member's overall health, significant functional impairment, or deterioration of health status.

Handicapping Malocclusion

A malocclusion that results in functional impairment, impacts normal oral function, or is associated with a qualifying craniofacial condition.

Criteria:

The following conditions may require medically necessary orthodontic treatment when associated with functional impairment and supported by clinical documentation:

1. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
   - History of cleft lip and/or palate repair (unilateral or bilateral)
   - Craniosynostosis, syndromic or non-syndromic (e.g., Crouzon, Apert)
   - Hypertrophy/Congenital Hemifacial Hyperplasia
   - Hemifacial microsomia with mandibular hypoplasia or facial asymmetry
   - Other craniofacial syndromes (e.g., Treacher Collins, Goldenhar, Pierre Robin sequence)

- Malocclusion or skeletal discrepancy directly caused by a craniofacial condition
- Functional deficits related to jaw or occlusal abnormalities, such as:
  - Difficulty with mastication or swallowing
  - Impaired speech function
  - Airway compromise or other medically significant functional impact

A physician examination, including documentation of Body Mass Index (BMI) is required to support functional impairment and overall medical necessity.

2. Traumatic injuries resulting in skeletal or dentofacial deformities requiring surgical and orthodontic treatment.
3. Skeletal discrepancies involving maxillary and/or mandibular structures (e.g., severe Class II or Class III malocclusions, anterior or lateral open bites).

Required Documentation:

1. Orthodontic treatment plan and clinical notes describing the severe handicapping malocclusion.
2. Panoramic radiographs and/or full-mouth radiographs.
3. Cephalometric X-ray with tracing and teeth in centric occlusion.
4. Facial photographs (frontal and profile views).
5. Intra-oral photographs (right, left, anterior occlusal views).
6. Maxillary and mandibular occlusal photographs or study models (or CAD equivalent).
7. Surgical treatment plan and letter of medical necessity when orthognathic surgery is planned.
8. Physician documentation, including BMI, when required.

Orthognathic Surgery

Orthognathic surgery is the surgical correction of skeletal abnormalities of the mandible, maxilla, or both that result in significant functional impairment and cannot be adequately corrected with orthodontic treatment alone. The underlying skeletal abnormality may be congenital, present at birth, or may become apparent as the member grows and develops. Skeletal deformities may also be acquired, resulting from traumatic injury or secondary to systemic disease.

In cases of severe skeletal or dentofacial deformity, the severity of the condition may require orthognathic surgery in combination with pre-surgical and post-surgical orthodontic treatment and other rehabilitative services. Treatment is provided as part of a comprehensive treatment plan designed to restore proper occlusion, mastication, speech, and overall oral function. Orthognathic surgery is not performed for cosmetic purposes alone.

Orthognathic surgery for dentofacial conditions requires a collaborative approach between a licensed oral and maxillofacial surgeon and an orthodontist to ensure appropriate treatment planning, sequencing, and functional outcomes. Orthodontic

consultation may be required to confirm that surgical correction is necessary or to determine whether adequate functional improvement can be achieved with orthodontic therapy alone.

Orthodontic Objectives

Pre-surgical and post-surgical orthodontic treatment may include the following objectives:

1. Alignment and leveling of teeth over the basal bone
2. Correction of dental compensations
3. Establishment of transverse arch width
4. Establishment of proper incisor inclination

Orthognathic Surgical Objectives

Orthognathic procedures may include mandibular and/or maxillary surgery, such as:

1. Maxillary osteotomy
2. Mandibular osteotomy
3. Bimaxillary osteotomy
4. Surgical split osteotomy of the mandibular ramus
5. Vertical ramus osteotomy

The following procedures are considered orthognathic surgery when performed to address functional impairment:

1. Reconstruction of the mandibular ramus
2. Mandibular and/or maxillary osteotomy
3. Reconstruction of the mandible and/or maxilla related to functional correction

Removable and fixed appliance therapy (harmful habits treatment)

Removable or fixed appliance therapy for harmful oral habits may be considered medically necessary when the clinical record supports the need for appliance-based treatment after conservative efforts have not resolved the habit.

1. The documentation identifies a persistent oral habit, such as thumb sucking or tongue thrusting, and shows that behavior guidance alone was not successful or is not expected to correct the condition.
2. The clinical findings show an associated malocclusion that is consistent with the documented oral habit and supports the requested removable or fixed appliance therapy.

Limitations and Exclusions:

1. Blue Cross Blue Shield of Arizona Health Choice excludes coverage for orthodontic services and orthognathic surgery, including comprehensive orthodontics, interceptive orthodontics, and orthodontic retention, unless the services meet established medical necessity criteria.
2. Orthodontic or orthognathic surgery performed solely to improve facial appearance, without the presence of significant malocclusion, is considered cosmetic and is not covered.
3. Blue Cross Blue Shield of Arizona Health Choice does not cover orthodontic services that are performed solely for cosmetic purposes. This includes services intended to correct crowded dentition or excessive spacing between teeth when there is no associated functional impairment. Orthodontic treatment to correct a malocclusion

that is not considered dysfunctional does not meet medical necessity criteria, and minor malocclusion corrections are considered cosmetic and are not covered.

4. Orthodontic and orthognathic surgery for the treatment of temporomandibular joint (TMJ) disorders is considered investigational and is not covered. Current scientific literature does not support orthognathic surgery for TMJ dysfunction due to the lack of a proven cause-and-effect relationship between occlusion and TMJ disorders.
5. Orthodontic retention, including the removal of appliances and the construction and placement of retainers, will not be approved unless the initial comprehensive or interceptive orthodontic treatment was approved by Blue Cross Blue Shield of Arizona Health Choice as medically necessary.
6. Removal of fixed orthodontic appliances for reasons other than completion of treatment (D8695) is not covered, except when early removal is clinically warranted. Acceptable circumstances include:
    - Member deployment that disrupts continuity of orthodontic care
    - The need to remove appliances prior to starting chemotherapy or radiation therapy involving the head or neck region

This procedure includes assessment, preparation, removal of brackets and wires, cleaning, polishing, and evaluation for future treatment needs. Consultation with an orthodontist is required to determine whether early removal is appropriate. This procedure code is allowed once per lifetime.

7. AHCCCS and Blue Cross Blue Shield of Arizona Health Choice do not cover orthodontic services and orthognathic surgery for Medicaid members age 21 and older.
8. Orthodontic services and orthognathic surgery are not covered for Medicare members under the supplemental dental benefits provided by Health Choice Pathway.
9. In certain cases, exceptions may be made for approval of orthodontic treatment for continuity of care when a member transfers from another state or health plan and is already receiving approved orthodontic treatment. Documentation of prior approval by a Medicaid health plan and the member's current treatment status must be provided for review.

Coding/Billing

The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by medical/dental necessity criteria and specific benefit plans or other regulatory conditions. This list of codes may not be all inclusive.

CDT codes

Key:
C……Covered service
N……Non-covered service

Code	Description	Medicaid Age 0-20	Medicaid Age 21+	Medicare HCP
D8010	Limited orthodontic treatment of the primary dentition	C	N	N
D8020	Limited orthodontic treatment of the transitional dentition	C	N	N
D8030	Limited orthodontic treatment of the adolescent dentition	C	N	N
D8040	Limited orthodontic treatment of the adult dentition	C	N	N
D8070	Comprehensive orthodontic treatment of the transitional dentition	C	N	N
D8080	Comprehensive orthodontic treatment of the adolescent dentition	C	N	N
D8090	Comprehensive orthodontic treatment of the adult dentition	C	N	N
D8210	Removable appliance therapy	C	N	N
D8220	Fixed appliance therapy	C	N	N
D8660	Pre-orthodontic treatment examination to monitor growth and development	C	N	N
D8670	Periodic orthodontic treatment visit	C	N	N
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	C	N	N
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	C	N	N
D8696	Repair of orthodontic appliance-maxillary	C	N	N
D8697	Repair of orthodontic appliance-mandibular	C	N	N
D8698	Re-cement or re-bond fixed retainer-maxillary	C	N	N
D8699	Re-cement or re-bond fixed retainer-mandibular	C	N	N
D8701	Repair of fixed retainer, includes reattachment-maxillary	C	N	N
D8702	Repair of fixed retainer, includes reattachment-mandibular	C	N	N
D8703	Replacement of lost or broken retainer-maxillary	C	N	N
D8704	Replacement of lost or broken retainer-mandibular	C	N	N
D8999	Unspecified orthodontic procedure, by report	C	N	N

NOT covered CDT codes:

Codes	Description
D8681	Removable orthodontic retainer adjustment

References:

- American Dental Association (ADA); CDT 2026 Dental Procedure Code Book.
- American Academy of Pediatric Dentistry Guideline on Dental Management of Pediatric Patients Receiving Chemotherapy, Hematopoietic Cell Transplantation, and/or Radiation Therapy. Revised 2022.
- American Association of Orthodontists Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics 2025.
- American Association of Orthodontists Glossary 2024.
- American Association of Orthodontists House of Delegates. Medically Necessary Orthodontic Care. May 2019.
- American Academy of Pediatric Dentistry. Policy on the management of patients with cleft lip/palate and other craniofacial anomalies. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2025:79.
- American Cleft Palate Craniofacial Association. Parameters of Care For Evaluation and Treatment of Individuals with Cleft Lip/Palate and/or Other Craniofacial Condition. 2024.
- AHCCCS Medical Policy Manual Chapter 400 – Maternal and Child Health 431- Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment Aged Members.
- AHCCCS Medical Policy Manual Chapter 300-Covered Services- 310-D1–Dental Services for Members 21 Years of Age And Older.
- Health Choice Pathway 2026 CPT and CDT codes for Supplemental Benefits.

Policy History/Review Date:

Developed Date	11/01/2013
Last Review Date	10/2026
Next Review Date	10/2027

This policy will be reviewed on an annual basis.