PRIOR AUTHORIZATION for ORTHOGNATHIC SURGERY

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Provider Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**
Facility Address:	**Facility Phone:** ( )	**Facility Facsimile:** ( )
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**	

Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-auth requirement.*

Procedure/Service: _____ CPT/HCPCS code: _____

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Procedure/Service: _____ CPT/HCPCS code: _____

Procedure/Service: _____ CPT/HCPCS code: _____

Procedure/Service: _____ CPT/HCPCS code: _____

Procedure/Service: _____ CPT/HCPCS code: _____

(Please check indication for surgery being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
A. ☐ <u>Maxillary and/or Mandibular Facial Skeletal Deformities Associated with Masticatory Malocclusion:</u> 1. Is the skeletal deformity contributing to significant masticatory dysfunction?	☐	☐	
2. Is the deformity so severe that it precludes adequate treatment through dental therapeutics and orthodontics?	☐	☐	
3. **<u>Anteroposterior Discrepancies:</u>** 3. a. Is the maxillary/mandibular incisor relationship over jet ≥5 millimeter (mm) or a 0 to negative value (norm is 2mm)?	☐	☐	
3. b. Is the maxillary/mandibular anteroposterior molar relationship discrepancy ≥ 4 mm (norm is 0 to 1 mm)?	☐	☐	
4. **<u>Vertical Discrepancies:</u>** 4. a. (Open Bite) Is there vertical overlap of anterior teeth greater than 2 mm?	☐	☐	
4. b. (Open Bite) Is the unilateral or bilateral posterior open bite greater than 2 mm?	☐	☐	
4. c. Does the patient have a deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch?	☐	☐	
4. d. Does the patient have supraeruption of a dentoalveolar segment due to lack of opposing occlusion creating dysfunction not amendable to conventional prosthetics?	☐	☐	

PEHP Health & Benefits

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

(Please check indication for surgery being requested.) **QUESTION *(cont'd)***	**YES**	**NO**	**COMMENTS/NOTES**
5. **Transverse Discrepancies:** 5. a. Is the total bilateral maxillary palatal cusp to mandibular fossa discrepancy 4mm or greater?	☐	☐	
5. b. Is there a unilateral discrepancy of 3 mm or greater given normal axial inclination of the posterior teeth?	☐	☐	
6. **Asymmetries**: Is there an anteroposterior, transverse, or lateral asymmetry greater than 3 mm with concomitant occlusal asymmetry?	☐	☐	
B. ☐ Facial Skeletal Discrepancies Associated with Sleep Apnea, Airway Defects, & Soft Tissue Discrepancies: 1. Is there documentation that mandibular and maxillary deformity are contributing to airway dysfunction?	☐	☐	
2. Is the dysfunction not amendable to non-surgical treatments?	☐	☐	
3. Has it been shown that orthognathic surgery will decrease airway resistance and improve breathing? *For example, studies demonstrate that persons with vertical hyperplasia of the maxilla have an associated increase in nasal resistance. After orthognathic surgery, such individuals routinely demonstrate decreases in airway resistance and improved respiration?*	☐	☐	
C. ☐ Obstructive Sleep Apnea (OSA): 1. Is jaw realignment surgery being requested because the underlying craniofacial skeletal deformity is contributing to obstructive sleep apnea (OSA)?	☐	☐	
2. Has the patient failed all other treatment approaches for obstructive sleep apnea (OSA)?	☐	☐	
D. ☐ Temporomandibular Joint Pathology: 1. Is orthognathic surgery being requested to correct temporomandibular joint disease?	☐	☐	
2. Is orthognathic surgery being requested to correct myofascial pain dysfunction?	☐	☐	
E. ☐ Speech Impairments: 1. Is orthognathic surgery being requested for treatment of speech impairments accompanying severe cleft deformity?	☐	☐	
2. Is orthognathic surgery being requested for correction of articulation disorders or other impairments in the production of speech?	☐	☐	
3. Is orthognathic surgery being requested for correction of distortions within the sibilant sound class or for other distortions of speech quality (e.g., hyper-nasal or hypo-nasal speech)?	☐	☐	
F. ☐ Unaesthetic Facial Features and Psychological Impairments: 1. Is orthognathic surgery being requested to correct an unaesthetic facial feature?	☐	☐	
2. Is orthognathic surgery being requested to correct an unaesthetic facial feature associated with a psychological disorder?	☐	☐	
3. Will a mentoplasty or genial osteotomy/ostectomy (chin surgery) be performed as an isolated procedures to address genial hypoplasia, hypertrophy, or asymmetry?	☐	☐	

Additional Comments:

Please fax completed form and medical records to 801-366-7449.