Clinical Policy Bulletin:  
Orthognathic Surgery

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Policy

Certain jaw and cranio-facial deformities may cause significant functional impairment. These deformities include apertognathia (either lateral or anterior not correctable by orthodontics alone), significant asymmetry of the lower jaw, significant class 2 and class 3 occlusal discrepancies, and cleft palate. Aetna considers orthognathic surgery medically necessary for correction of the following skeletal deformities of the maxilla or mandible when it is documented that these skeletal deformities are contributing to significant dysfunction, and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics alone:

I. Maxillary and/or Mandibular Facial Skeletal Deformities Associated with Masticatory Malocclusion

Aetna considers orthognathic surgery medically necessary for correction of skeletal deformities of the maxilla or mandible when it is documented that these skeletal deformities are contributing to significant masticatory dysfunction, and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics:

A. Antero-posterior discrepancies

1. Maxillary/mandibular incisor relationship: overjet of 5 millimeter (mm) or more, or a 0 to a negative value (norm 2 mm),
2. Maxillary/mandibular antero-posterior molar relationship discrepancy of 4 mm or more (norm 0 to 1 mm).

Note: These values represent 2 or more standard deviations (SDs) from published norms.

B. Vertical discrepancies
1. Presence of a vertical facial skeletal deformity which is 2 or more SDs from published norms for accepted skeletal landmarks

2. Open Bite
   a. No vertical overlap of anterior teeth greater than 2 mm
   b. Unilateral or bilateral posterior open bite greater than 2 mm

3. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch

4. Supraeruption of a dento-alveolar segment due to lack of opposing occlusion creating dysfunction not amenable to conventional prosthetics.

C. Transverse discrepancies

1. Presence of a transverse skeletal discrepancy which is 2 or more SDs from published norms.
2. Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.

D. Asymmetries

1. Antero-posterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry.

II. Facial Skeletal Discrepancies Associated with Documented Sleep Apnea, Airway Defects, and Soft Tissue Discrepancies

Aetna considers orthognathic surgery medically necessary in cases where it is documented that mandibular and maxillary deformities are contributing to airway dysfunction, where such dysfunction is not amenable to non-surgical treatments, and where it is 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, as do persons with maxillary hypoplasia with or without clefts. Following orthognathic surgery, such individuals routinely demonstrate decreases in nasal airway resistance and improved respiration.

Aetna considers orthognathic surgery medically necessary for members with underlying craniofacial skeletal deformities that are contributing to obstructive sleep apnea. See CPB 0004 - Obstructive Sleep Apnea in Adults. Before surgery, such individuals should be properly evaluated to determine the cause and site of their disorder and appropriate non-surgical treatments attempted when indicated.
III. Temporomandibular Joint Pathology

Aetna considers orthognathic surgery for correction of temporomandibular joint disease or myofascial pain dysfunction experimental and investigational because its effectiveness for these indications has not been established. See CPB 0028 - Temporomandibular Disorders.

IV. Speech Impairments

Aetna considers orthognathic surgery medically necessary for treatment of speech impairments accompanying severe cleft deformity. Orthognathic surgery may help to reduce the flattening of the face that is characteristic of severe cleft deformity. By using osteotomy techniques along with bone and cartilage grafts, the upper and lower jaws and facial skeletal framework are moved and appropriately reconstructed. Pre-surgical orthodontic treatment is usually recommended.

Aetna considers other orthognathic surgeries experimental and investigational for correction of articulation disorders and other impairments in the production of speech because there is inadequate evidence from prospective clinical studies in the peer-reviewed published medical literature of the effectiveness of orthognathic surgery for this indication.

Aetna considers orthognathic surgery for correction of distortions within the sibilant sound class or for other distortions of speech quality (e.g., hyper-nasal or hypo-nasal speech) not medically necessary as these distortions do not cause functional impairment.

V. Unesthetic Facial Features and Psychological Impairments

Orthognathic surgery is considered cosmetic for correction of unesthetic facial features.

Mentoplasty or genial osteotomies/ostectomies (chin surgeries) are always considered cosmetic when performed as an isolated procedure to address genial hypoplasia, hypertrophy, or asymmetry, and may be considered cosmetic when performed with other surgical procedures.

No benefits are available for orthognathic surgery performed primarily for cosmetic purposes. See Aetna CPB 0031 - Cosmetic Surgery.

VI. Aetna considers the use of condylar positioning devices in orthognathic surgery experimental and investigational because their effectiveness in orthognathic surgery has not been established.

VII. Aetna considers orthognathic surgery experimental and investigational for all indications other than those listed above because their effectiveness for indications other than the ones listed above has not been established.

VIII. Aetna considers three-dimensional virtual treatment planning of orthognathic surgery experimental and investigational because its effectiveness has not been established.
Note: Precertification requests or claims for orthognathic surgery are subject to review by Aetna's Oral and Maxillofacial Surgery Unit.

Orthodontic Treatment Prior to Orthognathic Surgery

Note: Expenses associated with the orthodontic phase of care (both pre- and post-surgical) are considered dental in nature and are not covered under Aetna's medical plans. See CPB 0082 - Dental Services and Oral and Maxillofacial Surgery: Coverage Under Medical Plans.

Orthodontic treatment may be needed prior to orthognathic surgery to position the teeth in a manner that will provide for an adequate occlusion following surgical repositioning of the jaws. For plans that require precertification, orthognathic surgery must be precertified prior to pre-surgical orthodontic treatment. The interim occlusion that is achieved by orthodontic treatment may be dysfunctional prior to the completion of the orthognathic surgical phase of the treatment plan. Therefore, all requests for orthognathic surgery must be reviewed/precertified by an the Aetna Oral and Maxillofacial Surgery Unit prior to the initiation of pre-surgical orthodontic care. Failure to obtain precertification of orthognathic surgery prior to orthodontic care may result in the denial of benefits.

Documentation Requirements

Note: Orthognathic surgery may be subject to precertification review in plans that include precertification requirements. The following documentation should be forwarded to Aetna's Oral and Maxillofacial Surgery Unit for review: a written explanation of the member's clinical course, including dates and nature of any previous treatment; physical evidence of a skeletal, facial or craniofacial deformity defined by study models and pre-orthodontic imaging; and a detailed description of the functional impairment considered to be the direct result of the skeletal abnormality.

See also CPB 0082 - Dental Services and Oral and Maxillofacial Surgery: Coverage Under Medical Plans.

Background

Orthognathic surgery is the revision by ostectomy, osteotomy or osteoplasty of the upper jaw (maxilla) and/or the lower jaw (mandible) intended to alter the relationship of the jaws and teeth. These surgical procedures are intended (i) to correct skeletal jaw and cranio-facial deformities that may be associated with significant functional impairment, and (ii) to reposition the jaws when conventional orthodontic therapy alone is unable to provide a satisfactory, functional dental occlusion within the limits of the available alveolar bone. Congenital or developmental defects can interfere with the normal development of the face and jaws. These birth defects may interfere with the ability to chew properly, and may also affect speech and swallowing. In addition, trauma to the face and jaws may create skeletal deformities that cause significant functional impairment. Functional deficits addressed by this type of surgery are those that affect the skeletal
masticatory apparatus such that chewing, speaking and/or swallowing are impaired.

There is limited evidence of the effectiveness of orthognathic surgery on temporomandibular disorders. Abrahamsson et al (2007) examined if orthognathic surgery does affect the prevalence of signs and symptoms of temporomandibular disorders (TMDs). A literature survey in the PubMed and Cochrane Library electronic databases was performed and covered the period from January 1966 to April 2006. The inclusion criteria were controlled, prospective or retrospective studies comparing TMDs before and after orthognathic surgery in patients with malocclusion. There were no language restrictions, and 3 reviewers selected and extracted the data independently. The quality of the retrieved articles was evaluated by 4 reviewers. The search strategy resulted in 467 articles, of which 3 met the inclusion criteria. Because of few studies with unambiguous results and heterogeneity in study design, the scientific evidence was insufficient to evaluate the effects that orthognathic surgery had on TMD. Moreover, the studies had problems with inadequate selection description, confounding factors, and lack of method error analysis. The authors concluded that to obtain reliable scientific evidence, additional well-controlled and well-designed studies are needed to determine how and if orthognathic surgery alters signs and symptoms of TMD.

Lindenmeyer et al (2010) performed a systematic review of the best available research literature investigating the relation of oral and maxillofacial surgical procedures to the onset or relief of chronic painful TMD. A comprehensive review of the databases CINAHL, Cochrane Library, Embase, Medline, NHS Evidence--Oral Health, PsyclINFO, Web of Knowledge, and MetaLib was undertaken by 2 authors up to June 2009 using search terms appropriate to establishing a relation between orofacial surgical procedures and TMD. The search was restricted to English-language publications. Of the 1,777 titles reviewed, 35 articles were critically appraised, but only 32 articles were considered eligible. These were observational studies that fell into 2 groups; 9 were seeking to establish a surgical cause for TMD. Of these, only 2 of a series of 3 claimed that there was a significant link, but this claim was based on weak data (health insurance records) and was abandoned in a subsequent report. Twenty-three studies were seeking to achieve relief by orthognathic surgical intervention. These were also negative overall, with 7 articles showing varying degrees of mostly non-significant improvement, whereas 16 showed no change or a worse outcome. No published report on the putative effect of implant insertion was found. The authors concluded that these apparently contradictory approaches underline a belief that oral surgical trauma or gross malocclusion has a causative role in the onset of TMD. However, there was no overall evidence of a surgical causal etiology or orthognathic therapeutic value. This review emphasized that it is in the patients' best interest to carry out prospective appropriately controlled randomized trials to clarify the situation.

In a Cochrane review, Luther et al (2010) examined the effectiveness of orthodontic intervention in reducing symptoms in patients with TMD (compared with any control group receiving no treatment, placebo treatment or reassurance) and investigated if active orthodontic intervention leads to TMD. The Cochrane Oral Health Group's Trials Register, CENTRAL, MEDLINE and EMBASE were searched. Hand-searching of orthodontic journals and other related journals was
undertaken in keeping with the Cochrane Collaboration hand-searching program. No language restrictions were applied. Authors of any studies were identified, as were experts offering legal advice, and contacted to identify unpublished trials. Most recent search was April 13, 2010. All randomized controlled trials (RCTs) including quasi-randomized trials assessing orthodontic treatment for TMD were included. Studies with adults aged equal to or above 18 years old with clinically diagnosed TMD were included. There were no age restrictions for prevention trials provided the follow-up period extended into adulthood. The inclusion criteria required reports to state their diagnostic criteria for TMD at the start of treatment and for participants to exhibit 2 or more of the signs and/or symptoms. The treatment group included treatment with appliances that could induce stable orthodontic tooth movement. Patients receiving splints for 8 to 12 weeks and studies involving surgical intervention (direct exploration/surgery of the joint and/or orthognathic surgery to correct an abnormality of the underlying skeletal pattern) were excluded. The outcomes were: how well were the symptoms reduced, adverse effects on oral health and quality of life. Screening of eligible studies, assessment of the methodological quality of the trials and data extraction were conducted in triplicate and independently by 3 review authors. As no 2 studies compared the same treatment strategies (interventions) it was not possible to combine the results of any studies. The searches identified 284 records from all databases. Initial screening of the abstracts and titles by all review authors identified 55 articles that related to orthodontic treatment and TMD. The full articles were then retrieved and of these articles only 4 demonstrated any data that might be of value with respect to TMD and orthodontics. After further analysis of the full texts of the 4 studies identified, none of the retrieved studies met the inclusion criteria and all were excluded from this review. The authors concluded that there are insufficient research data on which to base clinical practice on the relationship of active orthodontic intervention and TMD. There is an urgent need for high quality RCTs in this area of orthodontic practice.

There is a lack of evidence to support the use of condylar positioning devices in orthognathic surgery. Costa et al (2008) stated that in the past few years, many devices have been proposed for preserving the pre-operative position of the mandibular condyle during bilateral sagittal split osteotomy. The authors stated that accurate mandibular condyle re-positioning is considered important to obtain a stable skeletal and occlusal result, and to prevent the onset of TMD. Condylar positioning devices (CPDs) have led to longer operating times, the need to keep inter-maxillary fixation as stable as possible during their application, and the need for precision in the construction of the splint or intra-operative wax bite. The authors reviewed the literature concerning the use of CPDs in orthognathic surgery since 1990 and their application to prevent skeletal instability and contain TMD since 1995. They concluded that there is no scientific evidence to support the routine use of CPDs in orthognathic surgery.

Stokbro et al (2014) stated that numerous publications regarding virtual surgical planning protocols have been published, most reporting only 1 or 2 case reports to emphasize the hands-on planning. None had systematically reviewed the data published from clinical trials. This systematic review analyzed the precision and accuracy of three-dimensional (3D) virtual surgical planning of orthognathic procedures compared with the actual surgical outcome following orthognathic surgery reported in clinical trials. These researchers performed a systematic
search of the current literature to identify clinical trials with a sample size of more than 5 patients, comparing the virtual surgical plan with the actual surgical outcome. Search terms revealed a total of 428 titles, out of which only 7 articles were included, with a combined sample size of 149 patients. Data were presented in 3 different ways: intra-class correlation coefficient, 3D surface area with a difference less than 2mm, and linear and angular differences in 3D. Success criteria were set at 2 mm mean difference in 6 articles; 125 of the 133 patients included in these articles were regarded as having had a successful outcome. Due to differences in the presentation of data, meta-analysis was not possible. The authors concluded that virtual planning appears to be an accurate and reproducible method for orthognathic treatment planning; a more uniform presentation of the data is necessary to allow the performance of a meta-analysis. Moreover, they stated that currently the software system most often used for 3D virtual planning in clinical trials is SimPlant (Materialise); more independent clinical trials are needed to further validate the precision of virtual planning.

Adolphs et al (2014) stated that within the domain of craniomaxillofacial surgery, orthognathic surgery is a special field dedicated to the correction of dentofacial anomalies resulting from skeletal malocclusion. Generally, in such cases, an inter-disciplinary orthodontic and surgical treatment approach is needed. After initial orthodontic alignment of the dental arches, skeletal discrepancies of the jaws can be corrected by distinct surgical strategies and procedures in order to achieve correct occlusal relations, as well as facial balance and harmony within individualized treatment concepts. To transfer the pre-operative surgical planning and re-position the mobilized dental arches with optimal occlusal relations, surgical splints are typically used. For this purpose, different strategies have been described which use 1 or more splints. Traditionally, these splints are manufactured by a dental technician based on patient-specific dental casts; however, computer-assisted technologies have gained increasing importance with respect to pre-operative planning and its subsequent surgical transfer. In a pilot study of 10 patients undergoing orthognathic corrections by a 1-splint strategy, 2 final occlusal splints were produced for each patient and compared with respect to their clinical usability. One splint was manufactured in the traditional way by a dental technician according to the preoperative surgical planning. After performing a CBCT scan of the patient’s dental casts, a second splint was designed virtually by an engineer and surgeon working together, according to the desired final occlusion. For this purpose, RapidSplint, a custom-made software platform, was used. After post-processing and conversion of the datasets into .stl files, the splints were fabricated by the PolyJet procedure using photo polymerization. During surgery, both splints were inserted after mobilization of the dental arches then compared with respect to their clinical usability according to the occlusal fitting. Using the workflow described above, virtual splints could be designed and manufactured for all patients in this pilot study. Eight of 10 virtual splints could be used clinically to achieve and maintain final occlusion after orthognathic surgery. In 2 cases virtual splints were not usable due to insufficient occlusal fitting, and even two of the traditional splints were not clinically usable. In five patients where both types of splints were available, their occlusal fitting was assessed as being equivalent, and in one case the virtual splint showed even better occlusal fitting than the traditional splint. In 1 case where no traditional splint was available, the virtual splint proved to be helpful in achieving the final occlusion. The authors
concluded that the findings of this pilot study demonstrated that clinically usable splints for orthognathic surgery can be produced by computer-assisted technology. Virtual splint design was realized by RapidSplint®, an in-house software platform which might contribute in future to shorten pre-operative workflows for the production of orthognathic surgical splints. The preliminary findings from this pilot study need to be validated by well-designed studies.

Swennen (2014) evaluated the timing for 3D virtual treatment planning of orthognathic surgery in the daily clinical routine. A total of 350 consecutive patients were included in this study. All patients were scanned following the standardized “Triple CBCT Scan Protocol” in centric relation. Integrated 3D virtual planning and actual surgery were performed by the same surgeon in all patients. The authors concluded that although clinically acceptable, still software improvements especially toward 3D virtual occlusal definition are mandatory to make 3D virtual planning of orthognathic surgery less time-consuming and more user-friendly to the clinician.

**CPT Codes / HCPCS Codes / ICD-9 Codes**

**CPT codes covered if selection criteria are met:**

- 21083 Impression and custom preparation; palatal lift prosthesis
- 21084 speech aid prosthesis
- 21085 oral surgical splint
- 21088 facial prosthesis
- 21141 Reconstruction midface, Lefort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
- 21142 2 pieces, segment movement in any direction, without bone graft
- 21143 3 or more pieces, segment movement in any direction, without bone graft
- 21145 single piece, segment movement in any direction, requiring bone grafts (includes obtaining graft)
- 21146 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
- 21147 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
- 21150 Reconstruction midface, Lefort II; anterior intrusion (e.g., Treacher-Collins Syndrome)

http://qawww.aetna.com/cpb/medical/data/1_99/0095_draft.html 03/04/2015
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>21151</td>
<td>any direction, requiring bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21154</td>
<td>Reconstruction mid-face, Lefort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without Lefort I</td>
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<tr>
<td>21155</td>
<td>with Lefort I</td>
</tr>
<tr>
<td>21159</td>
<td>Reconstruction mid-face, Lefort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without Lefort I</td>
</tr>
<tr>
<td>21160</td>
<td>with Lefort I</td>
</tr>
<tr>
<td>21181</td>
<td>Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial</td>
</tr>
<tr>
<td>21182</td>
<td>Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia) with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm</td>
</tr>
<tr>
<td>21183</td>
<td>total area of bone grafting greater than 40 sq cm but less than 80 sq cm</td>
</tr>
<tr>
<td>21184</td>
<td>total area of bone grafting greater than 80 sq cm</td>
</tr>
<tr>
<td>21188</td>
<td>Reconstruction midface, osteotomies (other than Lefort type) and bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21193</td>
<td>Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft</td>
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<tr>
<td>21194</td>
<td>with bone graft (includes obtaining graft)</td>
</tr>
<tr>
<td>21195</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation</td>
</tr>
<tr>
<td>21196</td>
<td>with internal rigid fixation</td>
</tr>
<tr>
<td>21198</td>
<td>Osteotomy, mandible, segmental;</td>
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<tr>
<td>21199</td>
<td>with genioglossus advancement</td>
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<tr>
<td>21206</td>
<td>Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>reduction</td>
</tr>
<tr>
<td>Code</td>
<td>Procedure Description</td>
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<tr>
<td>21210</td>
<td>Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)</td>
</tr>
<tr>
<td>21215</td>
<td>mandible (includes obtaining graft)</td>
</tr>
<tr>
<td>21230</td>
<td>Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)</td>
</tr>
<tr>
<td>21235</td>
<td>ear cartilage, autogenous, to nose or ear (includes obtaining graft)</td>
</tr>
<tr>
<td>21240</td>
<td>Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>21242</td>
<td>Arthroplasty, temporomandibular joint, with allograft</td>
</tr>
<tr>
<td>21243</td>
<td>Arthroplasty, temporomandibular joint, with prosthetic joint replacement</td>
</tr>
<tr>
<td>21247</td>
<td>Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)</td>
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<tr>
<td>21255</td>
<td>Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)</td>
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<tr>
<td>21270</td>
<td>Malar augmentation, prosthetic material</td>
</tr>
<tr>
<td>21275</td>
<td>Secondary revision of orbitocraniofacial reconstruction</td>
</tr>
<tr>
<td>21295</td>
<td>Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach</td>
</tr>
<tr>
<td>21296</td>
<td>intraoral approach</td>
</tr>
<tr>
<td>42200</td>
<td>Repair of palate</td>
</tr>
<tr>
<td>42281</td>
<td></td>
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</tbody>
</table>

**CPT codes not covered for indications listed in the CPB:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
</tr>
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<tbody>
<tr>
<td>21125</td>
<td>Augmentation, mandibular body or angle; prosthetic material</td>
</tr>
<tr>
<td>21127</td>
<td>with bone graft, onlay or interpositional (includes obtaining autograft)</td>
</tr>
</tbody>
</table>

**Other CPT codes related to the CPB:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
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</thead>
<tbody>
<tr>
<td>21110</td>
<td>Application of interdental fixation device for conditions other than fracture or dislocation, includes removal</td>
</tr>
<tr>
<td>21120</td>
<td>Genioplasty</td>
</tr>
<tr>
<td>21123</td>
<td></td>
</tr>
</tbody>
</table>

**HCPCS codes covered if selection criteria are met:**
D5954 - Palatal augmentation and lift prosthesis
D5959

D7940 - Other repair procedures
D7955

Other HCPCS codes related to the CPB:
D8010 - Orthodontics
D8999

ICD-9 codes covered if selection criteria are met:
524.00 - Major anomalies of jaw size and dental arch relationship
524.29

524.4 - Malocclusion and dentofacial functional abnormalities
524.59

749.00 - Cleft palate
749.04

749.20 - Cleft palate with cleft lip
749.25

327.23 Obstructive sleep apnea (adult) (pediatric) [associated with facial skeletal deformities]

ICD-9 codes not covered for indications listed in the CPB:
524.60 - Temporomandibular joint disorders
524.69

V50.1 Other plastic surgery for unacceptable cosmetic appearance

Other ICD-9 related to the CPB:
784.5 Other speech disturbance

786.00 - Dyspnea and respiratory abnormalities [associated with obstructive airway defects]
786.09

The above policy is based on the following references:


