AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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CLEFT LIP AND PALATE SURGERY Recommended Criteria for Third-Party Payer Coverage

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Background
The American Society of Plastic Surgeons (ASPS) is the largest organization of plastic surgeons in the world. Requirements for the membership include certification by the American Board of Plastic Surgery as recognized by the American Board of Medical Specialties. ASPS represents 97 percent of the board-certified plastic surgeons practicing in the United States and Canada. It serves as the primary educational resource for plastic surgeons and as their voice on socioeconomic issues. ASPS is recognized by the American Medical Association (AMA), the American College of Surgeons (ACS) and other organizations of specialty societies.

Definitions
In the U.S.A. approximately 7 percent of children are born with craniofacial deformities. The most common of these is cleft lip and/or cleft palate. The overall incidence of cleft lip and palate is one in 700 births making this deformity the fourth most common birth defect.

Cleft Lip
A cleft lip is a birth defect that results in a unilateral or bilateral opening in the upper lip between the mouth and the nose. It causes a deformity of the lip, nose and upper jaw.

Cleft Palate
A cleft palate is a birth defect characterized by an opening in the roof of the mouth, caused by a lack of tissue development. In this case, the mouth and nasal cavity, normally separated by the palate, are open to each other. The cleft can extend from the hard palate in the front of the mouth to the soft palate near the throat. Left unrepaired, a cleft palate will create feeding difficulties and lead to speech impediment, hearing loss and abnormal dental development.

For a child with cleft lip or cleft lip and palate, the anomalies can be either mild or severe and can cause complex distortion of facial structures. In addition to the initial closure of the lip and palate, many patients require secondary surgery involving the lip, palate, nose and jaw. The number of operations necessary to achieve a satisfactory final result depends on the type and degree of the patient’s cleft and associated problems. Adult patients who underwent repair of a cleft lip or palate may have marked residual deformities and impairments that require surgical reconstruction to approximate a normal appearance and function.

Cosmetic and Reconstructive Surgery
For reference, the following definitions of cosmetic and reconstructive surgery was adopted by the American Medical Association, June 1989.
Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient’s appearance and selfesteem.
Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Procedures
Primary surgery, cleft lip.

Cheiloplasty
Cheiloplasty, or cleft lip repair, is performed to close the opening in the lip caused by this birth defect. If the cleft is bilateral, closure may be performed on both sides simultaneously, or the surgeon may repair the lip one side at a time in separate surgeries. In some cases, when the deformity is severe, a preliminary operation to bring the two sides of the gap closer may be needed. The preliminary procedure can be either a lip adhesion (sewing the edges together without aligning the lip) or the insertion of an appliance to mechanically approximate the lip and gums.

The formal cleft lip repair is generally performed in a hospital under general anesthesia. There is more than one surgical approach. In a technique known as rotation-advancement lip repair, the surgeon makes an incision on either side of the cleft lip, extending into the nostrils. Working through the incision, the surgeon opens the lip completely, rotates the pink outer portion downward, and advances tissue from the cheek into the defect to eliminate the cleft. In another method, referred to as triangular flap repair, the surgeon makes incisions to form small skin flaps between the lip and nose. These flaps overlap and interlock to close the defect, restore muscle function, create needed height in the lip, and form a cupid's bow.

Primary surgery, cleft palate.

Palatoplasty
Palatoplasty, or cleft palate repair, is performed to close an opening in the palate. Surgeons may close the palate in one surgery when the child is about one year of age. Or, the palate may be closed in two stages, separating the hard and soft palate repairs. Palatoplasty is usually performed in a hospital under general anesthesia as an inpatient procedure. Methods for repairing a cleft palate may vary widely in terms of when they are performed and what techniques are used. In a typical repair, incisions are made in the palate to provide sufficient tissue to close the defect. This tissue is moved to the mid-line or the center of the mouth to reconstruct the palate, join the muscles and provide adequate length to the soft palate. During the palatoplasty, cheek fat may be brought into the repair as well as cheek (buccal) mucosal-muscle flaps to augment the repair and close the defect.

Secondary surgery
Since the face grows until a child has reached maturity (girls 16 and boys 19), children born with cleft lips and palates require monitoring, and additional procedures may be required to correct residual deformities or deformities which worsen with age.

Patients with cleft lip deformities also have distortion of the nose. Cleft lip rhinoplasty is necessary to improve nasal function and correct the distortion. In the case of a severe nasal deformity, reconstructive rhinoplasty may be done in the child's early years. However, in other cases it is recommended that the operation be performed in the child's middle teenage years, when the nose has attained its maximum growth. Secondary surgery to achieve optimum reconstruction is common.

Repair of a complete cleft palate, one that extends from the lip to the throat, is generally performed in two operations. However, later revisions are often needed by children because of scarring and impaired growth of the palate. Communication (fistula) between the oral cavity and the nose or maxillary sinus is a sequela of cleft palate procedures and requires surgical closure. An additional operation, a bone graft commonly from the skull, hip or rib, may be required to replace missing bone in the gum ridge (alveolus) of the mouth (alveoloplasty).

Cleft palate patients may also have abnormal speech development. As they grow older and begin to speak, air may escape from the nostrils in an abnormal way and cause hypernasality. A surgical procedure known as a pharyngoplasty (pharyngeal flap, palatal lengthening, or sphincter pharyngoplasty) is done to correct this deformity and permit normal speech.

Anomalies of the upper jaw (maxilla) develop as well, sometimes requiring surgical correction in the teenage years. If the maxilla is deficient (hypoplastic), it may require expansion or realignment by osteotomy to correct the malocclusion and abnormal jaw relation (orthagnathic surgery).

Documentation

When cleft lip and palate and secondary deformities are repaired, the indications should be documented by the surgeon in the history and physical and reiterated in the operative note. Chart documentation of the presence of a cleft lip or palate or other secondary deformity should qualify a procedure as medically necessary and, therefore, eligible for coverage. Photographs are usually taken to document the pre-operative condition and aid the surgeon in planning surgery. In some cases they may record physical signs; however, they do not substantiate symptoms and should only be used by third-party payers in conjunction with less subjective documentation. In circumstances when photographs may be useful to a third-party payer, the plastic surgeon should provide them. The patient, however, must sign a specific release, and confidentiality must be honored. It is the opinion of ASPS that a board-certified plastic surgeon should evaluate all submitted photographs.

Position Statement

Initial repair of cleft lip and palate deformities is generally performed at an early age, but secondary surgery may be required as the patient grows older and the lip, palate, nasal and jaw structures grow and develop. It is the position of the American Society of Plastic Surgeons that both initial and secondary procedures for treatment of cleft lip and palate birth defects should be compensable by third party payers, regardless of the patient's age.

CODING AND BILLING

CPT Codes

21076 - Impression and custom preparation; surgical obturator prosthesis
42280 – Maxillary impression for palatal prosthesis
40720 – Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure
40761 – Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
41872 - Gingivoplasty, each quadrant (specify)
15576-51- Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral
15630 - Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips
42950 - Pharyngoplasty (plastic or reconstructive operation on pharynx)
15576 Tongue flap: Anterior or posterior based pedicle flap

92511 - Nasopharyngoscopy with endoscope (separate procedure)
12051 - Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
13151 - Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
14060 - Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15574 - Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
21141 - Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142 - Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143 - Reconstruction midface, LeFort I; 3 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) (eg, ungrafted unilateral alveolar cleft)
21147 - Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21206 - Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
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)
21235 - Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
30130 - Excision inferior turbinate, partial or complete, any method
30140 - Submucous resection inferior turbinate, partial or complete, any method
30460 - Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462 - Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30520 - Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30580 - Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600 - Repair fistula; oronasal
40700 - Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701 - Plastic repair of cleft lip/nasal deformity; primary bilateral, 1-stage procedure
40702 - Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages
42145 - Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42205 - Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210 - Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)

42215 - Palatoplasty for cleft palate; major revision
42220 - Palatoplasty for cleft palate; secondary lengthening procedure
42225 - Palatoplasty for cleft palate; attachment pharyngeal flap
42226 - Lengthening of palate, and pharyngeal flap
42227 - Lengthening of palate, with island flap
42235 - Repair of anterior palate, including vomer flap
42260 - Repair of nasolabial fistula
42281 - Insertion of pin-retained palatal prosthesis

ICD-10 Codes

Q30.2 - Fissured, notched and cleft nose
Q38.0 - Congenital Malformation Lips Not Elsewhere Classified (Van der Woude Syndrome)
Q38.5 - Congenital High Arched Palate
Q38.8 - Other congenital malformations of pharynx
O35.8XX0 - Maternal care for other (suspected) fetal abnormality and damage, unspecified
Q87.0 - Congenital malformation syndromes predominantly affecting facial appearance (Pierre Robin Sequence)
Q18.4 - Macrostomia
Q35.1 - Cleft hard palate
Q35.3 - Cleft soft palate
Q35.5 - Cleft hard palate with cleft soft palate
Q35.7 - Cleft uvula
Q35.9 - Cleft palate, unspecified
Q36.0 - Cleft lip, bilateral
Q36.1 - Cleft lip, median
Q36.9 - Cleft lip, unilateral
Q37.0 - Cleft hard palate with bilateral cleft lip
Q37.1 - Cleft hard palate with unilateral cleft lip
Q37.2 - Cleft soft palate with bilateral cleft lip
Q37.3 - Cleft soft palate with unilateral cleft lip
Q37.4 - Cleft hard and soft palate with bilateral cleft lip
Q37.5 - Cleft hard and soft palate with unilateral cleft lip
Q37.8 - Unspecified cleft palate with bilateral cleft lip
Q37.9 - Unspecified cleft palate with unilateral cleft lip

References

Clasper, R. “A combined obturator and expansion appliance for use in patients with patent oral-nasal fistula.” Bristish Journal of Orthodontics, 22(4): 357, Nov. 1995.

Cronin, T.D. et al. “Bilateral Clefts,” In: Plastic Surgery, McCarthy, J.C. Vol. 4, p. 2653, W.B. Saunders: 1990.

Furlow, L.T. “Flaps for Cleft Lip and Palate Surgery.” Clinics in Plastic Surgery, Vol. 17, p. 633, 1990. Jackson, I.T., et al. “Secondary Deformities of Cleft Lip, Nose and Palate.” In: Plastic Surgery, McCarthy, J.G. Vol. 4 p. 2771, W.B. Saunders, 1990.

McComb, H. “ Primary Correction of Unilateral Cleft Lip & Nasal Deformity: A10 year review.” Plastic and Reconstructive Surgery, 75: 791, 1985. Millard, D. R. “Unilateral Cleft Lip Deformity” In: Plastic Surgery, McCarthy, J. G. Vol 4 p. 2627, 1990.

Randell, P. “A triangular flap operation for the primary repair of unilateral clefts of the lip. Plast. Reconstr. Surg., 23:331, 1959.

Smith, W.P. “ Primary Closure of the Cleft Alveolus: A Functional Approach.” British Journal of Oral & Maxillofacial Surgery, 33: 156- 165, 1995.

Thaller, S. “Microform Cleft Lip Associated with a Complete Cleft Palate.” Cleft Palate-Craniofacial Journal, Vol. 32, No. 3, pp. 247-250, May, 1995.

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