# Temporomandibular Joint Disorder Treatment

**Policy Number:** OCA 3.968  
**Version Number:** 11  
**Version Effective Date:** 01/14/16

## Product Applicability

<table>
<thead>
<tr>
<th>All Plan* Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well Sense Health Plan</strong></td>
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<tr>
<td>- New Hampshire Medicaid</td>
</tr>
<tr>
<td>- NH Health Protection Program</td>
</tr>
<tr>
<td><strong>Boston Medical Center HealthNet Plan</strong></td>
</tr>
<tr>
<td>- MassHealth</td>
</tr>
<tr>
<td>- Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
</tr>
<tr>
<td>- Senior Care Options ◊</td>
</tr>
</tbody>
</table>

## Notes:

+ Disclaimer and audit information is located at the end of this document.  
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at [www.SeniorsGetMore.org](http://www.SeniorsGetMore.org) to determine coverage guidelines for Senior Care Options.

## Policy Summary

The Plan considers the treatment of a temporomandibular joint (TMJ) disorder to be medically necessary **only** when the disorder is caused by or results in a specific medical condition. Examples of specific medical conditions include but are not limited to jaw fractures and/or dislocations and degenerative arthritis. Prior authorization is required.

It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested use. See the Plan’s policy, *Medically Necessary* (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment. Review the member’s applicable benefit documents available at [www.bmchp.org](http://www.bmchp.org) for BMC HealthNet Plan members (or at

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www.SeniorsGetMore.org for Senior Care Options members) and www.wellsense.org for Well Sense Health Plan members for benefit coverage (including treatment guidelines and age-specific coverage) for the treatment of TMJ.

Description of Item or Service

Temporomandibular Joint (TMJ) Disorder Treatment: A variety of therapeutic services, ranging from non-surgical pharmaceutical therapy, physical therapy, and mandibular orthopedic repositioning appliances, to surgical procedures such as dislocation reduction, open arthroplasty with implant and vertical ramus osteotomy.

Medical Policy Statement

The Plan considers the treatment of a TMJ disorder to be medically necessary when the following medical criteria are met and documented in the member’s medical record:

A. Initial Medical Evaluation:

1. Prior authorization is NOT required for the initial medical evaluation of a TMJ disorder conducted by the treating physician or a licensed independent practitioner practicing within the scope of his/her license (i.e., nurse practitioner or physician assistant) when both of the following criteria are met, as specified below in item a and item b:

   a. Initial medical evaluation is part of a new patient office visit (and is billed as such with the appropriate CPT code and diagnosis code); AND

   b. The new patient office visit is conducted by a specialist with the expertise to evaluate the symptoms of TMJ disorders related to jaw fracture, dislocation of jaw, and/or degenerative arthritis and renders a diagnosis (as specified in the Applicable Coding section of this policy and item B1 of this Medical Policy Statement section); OR

2. Prior authorization is REQUIRED for the initial medical evaluation for a TMJ disorder when BOTH of the Plan criteria listed above in item A1a and item A1b are not met (using the criteria for treatment specified in item B below when the initial medical evaluation does require prior authorization).

B. Treatment After the Initial Evaluation:

Treatment after the initial evaluation requires prior authorization and must meet ALL of the following criteria, as specified below in items 1 through 3:

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1. Specific medical condition eligible for treatment includes at least ONE (1) of the following, as specified below in item a or item b:
   
a. Jaw fracture or dislocation; OR

   b. Degenerative arthritis; AND

2. The medical condition is confirmed by diagnostic x-rays or other generally accepted diagnostic procedures; AND

3. Based on the treatment plan determined by the treating provider, the applicable criteria for non-surgical treatment are met (as specified below in item a) or the applicable criteria for surgical treatment are met (as specified below in item b):

   a. **Criteria for Non-Surgical Treatment:**

   (Note: These criteria are applicable only when non-surgical treatment is requested.)

   Covered first-line treatment is non-surgical and conservative and may include but is not limited to ANY of the following (or a combination of the following), as specified below in items (1) through (4), as specified below in item a or item b:

   (1) Pharmacologic therapy such as anti-inflammatory, muscle relaxants, and/or analgesics; OR

   (2) Physical therapy; OR

   (3) Use of mandibular orthopedic repositioning appliances (MORA); OR

   (4) Therapeutic injections; OR

   b. **Criteria for Surgical Treatment:**

   (Note: These criteria are applicable only when surgical treatment is requested.)

   Surgical treatment is covered when ALL of the following criteria are met, as specified below in items (1) through (4):

   (1) Failure of non-surgical treatments (as specified above in item a) or conservative treatment is not indicated for treatment (e.g., fractures or dislocations) or is
contraindicated for the member’s medical condition, as determined by the treating provider; AND

(2) Continuing pain and functional disability (such as facial or pre-auricular pain, significant intermittent or persistent limitation in jaw mobility, or joint locking, popping, or crepitus); AND

(3) Meniscus displacement documented on imaging; AND

(4) Covered procedures when surgical treatment criteria are met include ANY of the following, as specified below in items (a) through (f):

(a) Arthrocentesis (e.g., for acute closed lock); OR

(b) Arthroscopic surgery (e.g., for arthritis); OR

(c) Intraoral vertical ramus osteotomy (IVRO) to correct internal derangements; OR

(d) Manipulation for reduction of fracture or dislocation; OR

(e) Open surgical procedure such as arthroplasty, condylectomy, meniscus or disc plication, or disc removal; OR

(f) TMJ arthroplasty with FDA-approved prosthetic implants only

Limitations

1. Plan Medical Director is required for treatment when Plan criteria specified in the Medical Policy Statement section of this policy are not met.

2. The following services are NOT covered for all applicable Plan products (including BMC HealthNet Plan members and Well Sense Health Plan members), as specified below in items a through g:

   a. Treatment of a TMJ disorder that is not proven to be caused by or to result in a specific medical condition; OR

   b. Treatment for TMJ syndrome; OR

   c. Appliances, other than a mandibular orthopedic repositioning appliance (MORA); OR

   d. **Plan** refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
d. Services, procedures, or supplies to adjust the height of teeth or in any other way restore occlusion, such as crowns, bridges or braces; OR

e. Ultrasonic doppler auscultation for diagnosing disorders of the temporomandibular joint;

f. Jaw tracking devices and iontophoresis; OR

g. The use of a TMJ arthroplasty implant that is not FDA approved.

3. Well Sense Health Plan Members Only:

   For a member enrolled in the NH Health Protection Program, benefit coverage for the medical and/or surgical (non-dental) treatment of a temporomandibular joint (TMJ) disorder is limited to a member age 19 or age 20 (i.e., age 20 until the member’s 21st birthday on the date of service) when Plan criteria are met; NH Health Protection Program members age 21 or older are not covered for the medical and/or surgical (non-dental) treatment of TMJ disorders (even when Plan criteria are met).

Definitions

**Temporomandibular Joint (TMJ):** The area directly in front of the ear on either side of the head where the upper jaw (maxilla) and the lower jaw (mandible) meet. The joints are complex and are composed of muscles, tendons, and bones which are used when chewing, talking, and yawning.

**Temporomandibular Joint (TMJ) Disorder:** Also known as myofascial pain dysfunction and Costen's syndrome, this is a group of complex disorders of the temporomandibular joint(s) causing pain and dysfunction of the jaw joint and muscles that control jaw movement. Treatment of TMJ disorder ranges from conservative to surgical, and the symptoms of TMJ disorder may include the following, as specified below in items 1 through 8:

1. Biting or chewing difficulty or discomfort
2. Clicking sound while chewing or opening the mouth
3. Dull, aching pain in the face
4. Earache
5. Grating sensation while chewing
6. Headache
7. Jaw pain or tenderness of the jaw
8. Reduced ability to open or close the mouth

**Temporomandibular Joint Syndrome:** Pain in the jaw joint with the following associated signs and symptoms: swelling, ear pain, tinnitus, hearing loss, muscle spasms, trouble swallowing, headache, dizziness, and/or locked jaw. Causes include disease (e.g., degenerative joint disease), trauma, wear and tear, or habits (such as nocturnal jaw clenching or teeth grinding). When the syndrome is a physical manifestation of psychological stress and no primary disorder of the joint itself is present, treatment is focused on behavioral modification (as opposed to joint repair).

### Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

<table>
<thead>
<tr>
<th>ICD-9 Diagnosis Codes</th>
<th>Description: Diagnoses Requiring Prior Authorization for Any Treatment</th>
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</thead>
<tbody>
<tr>
<td>524.60</td>
<td>Temporomandibular joint disorders, unspecified Temporomandibular joint-pain-dysfunction syndrome [TMJ]</td>
</tr>
<tr>
<td>524.61</td>
<td>Adhesions and ankylosis (bony or fibrous)</td>
</tr>
<tr>
<td>524.62</td>
<td>Arthralgia of temporomandibular joint</td>
</tr>
<tr>
<td>524.63</td>
<td>Articular disc disorder (reducing or non-reducing)</td>
</tr>
<tr>
<td>524.64</td>
<td>Temporomandibular joint sounds on opening and/or closing the jaw</td>
</tr>
</tbody>
</table>

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**ICD-10 Diagnosis Codes** | **Description: Diagnoses Requiring Prior Authorization for Any Treatment**
---|---
M26.60 | Temporomandibular joint disorder, unspecified
M26.61 | Adhesions and ankylosis of temporomandibular joint
M26.62 | Arthralgia of temporomandibular joint
M26.63 | Articular disc disorder of temporomandibular joint
M26.69 | Other specified disorders of temporomandibular joint

**Clinical Background Information**

Temporomandibular joint (TMJ) disorders generally fall into three (3) categories: myofascial pain, internal derangement of the joint, and degenerative arthritis. Symptomatic TMJ dysfunction is estimated to affect 28 percent of the adult population, with a smaller percentage experiencing severe impairment. The typical patient with TMJ dysfunction is a female aged 20-40 years who has experienced symptoms for 3-5 years due to the misdiagnosis of symptoms, particularly during childhood and adolescence.

Myofascial pain is the most common TMJ disorder and involves discomfort or pain in the muscles that control jaw function. Internal derangement of the joint involves a displaced disc, dislocated jaw or injury to the condyle. Degenerative arthritis refers to a group of inflammatory degenerative joint disorders that can affect the temporomandibular joints. Often there is no known cause for TMJ disorders and the progression is unclear. Symptoms worsen and ease over time. The clinical problem is complex, because TMJ dysfunction is multifactorial. A variety of pathologies may affect the TMJ, of which internal derangement is the most common. Causes of TMJ disorders are unclear but trauma to the jaw or temporomandibular joint causing fractures or dislocations and degenerative arthritis can contribute to the development of TMJ disorders.

Treatments ranging from conservative to surgical depend upon the severity of the disorder. First-line therapy includes ice packs, avoidance of extreme jaw movements such as chewing gum and eating hard foods; medications such as analgesics, anti-inflammatories and muscle relaxants; gentle stretching exercises, physical therapy, mandibular orthopedic repositioning appliances and therapeutic injections. Some irreversible treatments have not been proven to be effective and may even worsen the problem. These may include orthodontics to change the bite, crown and bridge work, grinding the teeth and repositioning splints. Surgical treatments are used as a last resort when conservative measures have failed. Examples of surgical treatments include arthrocentesis, manipulation for reduction of fracture or dislocation, arthroscopic surgery, condylectomy, meniscus or disc plication, disc removal, and TMJ arthroplasty with prosthetic implants.
References


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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>01/01/09 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, QIC, and Utilization Management Committee (UMC)</td>
</tr>
<tr>
<td>Internal Approval: 09/09/08: MPCTAC 09/30/08: UMC 10/22/08: QIC</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13

### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/22/09</td>
<td>No criteria changes. Updated references.</td>
<td>Version 2</td>
<td>09/22/09: MPCTAC 10/28/09: QIC</td>
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<tr>
<td>09/01/10</td>
<td>No changes to criteria. Updated references and coding.</td>
<td>Version 3</td>
<td>09/15/10: MPCTAC 11/22/10: QIC</td>
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<tr>
<td>09/01/11</td>
<td>Updated limitations and references.</td>
<td>Version 4</td>
<td>09/21/11: MPCTAC 10/26/11: QIC</td>
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<tr>
<td>07/01/12</td>
<td>References updated, revised language in the Applicable Coding section, and deleted four-digit diagnosis code 524.6.</td>
<td>Version 5</td>
<td>07/18/12: MPCTAC 08/22/12: QIC</td>
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<tr>
<td>07/29/12</td>
<td>Off cycle review for Well Sense Health Plan, revised Description of Service, reformatted the Medical Policy Statement, revised references.</td>
<td>Version 7</td>
<td>08/03/12: MPCTAC 09/05/12: QIC</td>
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<tr>
<td>01/30/14</td>
<td>Off cycle review for effective date</td>
<td>Version 8</td>
<td>01/27/14: MPCTAC</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Policy Revisions History</th>
<th>04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.</th>
<th>01/30/14: QIC</th>
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</thead>
<tbody>
<tr>
<td>09/01/14</td>
<td>Review for effective date 01/01/15. Revised language in the Limitations section related to benefit coverage. Revised medical criteria in the Medical Policy Statement and Limitations sections. Updated references.</td>
<td>01/01/15 Version 9 09/17/14: MPCTAC 10/08/14: QIC</td>
</tr>
<tr>
<td>09/01/15</td>
<td>Annual review for effective date 01/01/16. Revised the list of applicable products, including removing Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Revised criteria in the Medical Policy Statement and Limitations sections. Updated Clinical Background Information and References sections.</td>
<td>01/01/16 Version 10 09/16/15: MPCTAC 10/14/15: QIC</td>
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**Last Review Date**

11/25/15

**Next Review Date**

09/01/16

**Authorizing Entity**

QIC

**Other Applicable Policies**

Medical Policy - *Medically Necessary*, policy number OCA 3.14
Disclaimer Information: *

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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