Corporate Medical Policy

Temporomandibular Joint Dysfunction (TMJD)

File Name: temporomandibular_joint_dysfunction_(tmjd)
Origination: 1/1996
Last CAP Review: 10/2016
Next CAP Review: 10/2017
Last Review: 1/2017

Description of Procedure or Service

Temporomandibular joint (TMJ) dysfunction refers to a group of disorders characterized by pain in the TMJ and surrounding tissues. Initial conservative therapy is generally recommended; there are also a variety of nonsurgical and surgical treatment possibilities for patients whose symptoms persist. The etiology of TMJ disorders remains unclear and is believed to be multifactorial. TMJ disorders are often divided into two main categories; articular disorders (e.g., ankylosis, congenital or developmental disorders, disk derangement disorders, fractures, inflammatory disorders, osteoarthritis and joint dislocation) and masticatory muscle disorders (e.g., myofacial pain, myofibrotic contracture, myospasm and neoplasia).

There are no generally accepted criteria for diagnosing TMJ disorders. It is often a diagnosis of exclusion, and involves physical examination, patient interview, and dental record review. Diagnostic testing and radiologic imaging is generally only recommended for patients with severe and chronic symptoms.

Symptoms attributed to TMJD are varied and include, but are not limited to clicking sounds in the jaw; headaches; closing or locking of the jaw due to muscle spasms (trismus) or displaced disc; pain in the ears, neck, arms, and spine; tinnitus; and bruxism (clenching or grinding of the teeth).

For many patients, symptoms of TMJ dysfunction are short-term and self-limiting. Conservative treatments such as eating soft foods, rest, heat, ice, and avoiding extreme jaw movements, and anti-inflammatory medication, are recommended prior to consideration of more invasive and/or permanent therapies such as surgery.

Regulatory Status

Several muscle monitoring devices have received clearance from the U.S. Food and Drug Administration (FDA) through the 510(k) process since 1981. Some examples of these devices are: the K6-I Diagnostic System (Myotronics), the BioEMG III™ (Bio-Research Associates), and the GrindCare Measure (Medotech A/S). These devices aid clinicians in the analysis of joint sound, vibrations, and muscle contractions when diagnosing and evaluating TMJ dysfunction.

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

BCBSNC will provide coverage for the evaluation and treatment of Temporomandibular joint (TMJ) dysfunction when it is determined to be medically necessary because the medical criteria and guidelines shown below are met. Also see Policy Guidelines.
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Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design, and may include or exclude services commonly recommended for the evaluation and treatment of Temporomandibular Joint Dysfunction, such as, but not limited to, bite splints or oral orthotic appliances, physical therapy, and/or TMJ surgery. Braces and orthodontic treatment of TMJD are considered dental therapy and are not eligible under medical benefits. Therefore, member benefit language should be reviewed before applying the terms of this medical policy.

Treatment of TMJ included in this policy may require prior review (prior plan approval).

When Evaluation and Treatment of Temporomandibular Joint Dysfunction (TMJD) is covered

A. Diagnostic procedures.

MRI may be considered medically necessary when both of the following criteria are met:

1) Conservative measures noted below have not resolved signs and/or symptoms; and
2) The results of the MRI will impact decisions regarding surgical intervention.

Note: MRI may require prior review by BCBSNC’s diagnostic imaging management program.

B. Non-surgical treatments.

Short term physical therapy when administered by a licensed physical therapist (see Corporate Medical Policy titled “Rehabilitative Therapies”), intra-oral removable prosthetic devices/appliances (encompassing fabrication, insertion and adjustment), and arthrocentesis may be considered medically necessary when both of the following criteria are met:

1) Significant clinical symptoms and signs are present, including at least two of the following:
   a) Extra-articular pain related to muscles of the head and neck region, or earaches, headaches, masticatory or cervical myalgias;
   b) Painful chewing;
   c) Restricted range of motion, manifested by one of the following:
      (i) interincisal opening of less than 35 mm. (greatest distance between front upper teeth and lower front teeth when mouth is wide open); or
      (ii) lateral excursive movement of less than 4 mm. (side to side movement); or
      (iii) protrusive excursive movement of less than 4 mm. (front to back motion); or
      (iv) deviation on opening of greater than 5 mm. and
   2) Symptoms are not resolved by conservative treatment, including all of the following:
     a) Removal of precipitating activities (gum chewing, eating hard candies); and
     b) Pharmacological treatment (such as anti-inflammatory or analgesic medications (2 week trial); and
     c) 2 week trial of soft diet and proper chewing techniques;

C. Surgical treatments.

1) TMJ Surgery May be considered medically necessary when all of the following criteria are met:
   a) Signs and symptoms not resolved by conservative measures including standard splints (unless contra- indicated, e.g., anterior open bite and some Class III
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malocclusions), pharmacological treatment and physical therapy (unless contra-indicated); and
b) MRI or other radiology studies document TMJ abnormality noted in Stage III-V below; and
c) Underlying orthodontic disorders have been ruled out, or if present, treatment has been implemented (history, physical, and/or laboratory results must be documented with an assessment of the presence or absence of an orthodontic disorder).

2) The following surgical procedures may be considered medically necessary in the treatment of TMJD:
   a) Arthrocentesis
   b) Arthroscopic surgery in patients with objectively demonstrated (by physical examination or imaging) internal derangements (displaced discs) or degenerative joint disease who have failed conservative treatment.
   c) Open surgical procedures including, but not limited to, arthroplasties; condylectomies; meniscus or disc placation and disc removal when TMJD is the result of congenital anomalies, trauma, or disease in patients who have failed conservative treatment.
   d) Arthrotomy with total prosthetic joint replacement using the TMJ Concepts Patient Fitted TMJ Reconstruction Prosthesis™ is indicated for reconstruction of the TMJ for treatment of end-stage TMJ disease, when no other viable therapeutic alternatives are available.
      i. Patients should be considered for total prosthetic joint replacement if they have one or more of the following conditions:
         • Inflammatory arthritis involving the TMJ not responsive to other modalities of treatment;
         • Recurrent fibrous and/or bony ankylosis not responsive to other modalities of treatment;
         • Failed tissue graft;
         • Failed alloplastic joint reconstruction;
         • Loss of vertical mandibular height and/or occlusal relationship due to bone resorption, trauma, developmental abnormality, or pathologic lesion.
      ii. Total prosthetic joint replacement should not be used for patients with one or more of the following conditions:
         • Active or suspected infections in or about the implantation site;
         • Uncontrollable masticatory muscle hyperfunction (clenching or grinding) which may lead to overload and loosening of screws;
         • Known allergy to any of the component materials.
   e) Orthognathic Surgery – addressed in separate policy titled “Orthognathic Surgery.”
   f) Therapeutic manipulation of the TMJ requiring anesthesia (i.e., general or monitored anesthesia care) for reduction of fracture or dislocation of the TMJ.

<table>
<thead>
<tr>
<th>STAGE</th>
<th>CLINICAL</th>
<th>IMAGING</th>
<th>SURGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>I EARLY</td>
<td>Painless clicking</td>
<td>Minimally displaced disc-Normal osseous contours</td>
<td>Normal disc form - Slight displacement - Passive incoordination (clicking)</td>
</tr>
<tr>
<td></td>
<td>No restricted motion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II EARLY</td>
<td>Occasional painful clicking- Intermittent locking - Headaches</td>
<td>Early disc deformity and displacement. Normal osseous contours</td>
<td>Disc displacement - Thickened disc</td>
</tr>
<tr>
<td>INTERMEDIATE</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>III</td>
<td>Frequent pain - Joint tenderness -</td>
<td>Disc displacement - Moderate to marked disc thickening -</td>
<td>Disc deformed &amp; displaced – Variable adhesions -</td>
</tr>
<tr>
<td>INTERMEDIATE</td>
<td></td>
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</tbody>
</table>
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<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Imaging Findings</th>
<th>Bone Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Intermediate to Late</td>
<td>Chronic pain - Headache - Restricted motion</td>
<td>Disc displacement - Marked disc thickening - Abnormal bone contours</td>
<td>Degenerative remodeling of bony surfaces - Osteophytes - Adhesions - Deformed disc without perforation</td>
</tr>
<tr>
<td>V Late</td>
<td>Variable pain - Joint crepitus - Painful function</td>
<td>Disc displacement with disc perforation and gross deformity - Degenerative osseous changes</td>
<td>Gross degenerative changes of disc and hard tissues - Disc perforation - Multiple adhesions</td>
</tr>
</tbody>
</table>

*See under “When Covered” - A.

**When Evaluation and Treatment of Temporomandibular Joint Dysfunction (TMJD) is not covered**

1. Evaluation and treatment of temporomandibular joint dysfunction is considered **not medically necessary** when criteria are not met for the diagnostic tests and procedures addressed above.

2. The following **diagnostic procedures** are considered **investigational** in the diagnosis of TMJ dysfunction:
   - Electromyography (EMG), including surface EMG;
   - Kinesiography;
   - Thermography;
   - Neuromuscular junction testing;
   - Somatosensory testing;
   - Intra-oral tracing or gnathic arch tracing (intended to demonstrate deviations in the positioning of the jaws that are associated with TMJ dysfunction);
   - Muscle testing;
   - Computerized mandibular scan (this measures and records muscle activity related to movement and positioning of the mandible and is intended to detect deviations in occlusion and muscle spasms related to TMJ dysfunction);
   - Arthroscopy of the TMJ for purely diagnostic purposes;
   - Ultrasound imaging/sonogram;
   - Joint vibration analysis

3. The following **non-surgical treatments** are considered **investigational** in the treatment of TMJ dysfunction:
   - Electrogalvanic stimulation;
   - Iontophoresis;
   - Biofeedback;
   - Ultrasound;
   - Devices promoted to maintain joint range of motion and to develop muscles involved in jaw function;
   - Transcutaneous electrical nerve stimulation (TENS);
   - Percutaneous electrical nerve stimulation (PENS);
   - Hyaluronic acid
   - Alpha-stim
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- Trigger point and tender point injections

4. The following surgical treatments are considered investigational in the treatment of TMJ dysfunction:
   - Total joint replacement with the TMJ Fossa-Eminence/Condylar Prosthesis System™
   - Partial joint replacement with the TMJ Fossa-Eminence Prosthesis™

5. Surgical treatment for Stage I and II TMJD symptoms (see table above) is considered not medically necessary.

Policy Guidelines

At the present time, there is insufficient evidence in the published medical literature to demonstrate the safety, efficacy and long-term outcomes of the TMJ Fossa-Eminence/Condylar Prosthesis System™ for total joint replacement or the TMJ Fossa-Eminence Prosthesis™ for partial joint replacement. [Refer to separate policy, Investigational (Experimental) Services.]

The evidence for the use of ultrasound, surface electromyography, or joint vibration analysis in individuals who have suspected temporomandibular joint (TMJ) dysfunction includes systematic reviews of diagnostic test studies. Relevant outcomes are test accuracy and validity, and other performance measures. None of the systematic reviews found that these diagnostic techniques can accurately identify patients with TMJ and many of the included studies had methodological limitations. The evidence is insufficient to determine the effects of the technology on health outcomes.

For the intent of this policy, arthrocentesis for closed [jaw] lock (disc displacement without reduction) is considered advanced conservative management rather than a surgical procedure, and therefore does not need to meet the criteria for surgical treatment of temporomandibular joint dysfunction discussed in this policy.

For arthritic disorders affecting the temporomandibular joint, activity of the systemic disease should be considered prior to surgical intervention. In general, when the systemic disease is controlled with appropriate treatment, the medical necessity criteria outlined for internal derangement can be applied.

The evidence for the use of acupuncture, biofeedback, transcutaneous electrical nerve stimulation, orthodontic services, or hyaluronic acid in individuals who have a confirmed diagnosis of TMJ includes RCTs and systematic reviews of RCTs and observational studies. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The systematic reviews did not find that the above technologies improved pain and functional outcomes significantly more than control conditions. Many individual studies had small sample sizes and/or methodologic limitations. The evidence is insufficient to determine the effects of the technology on health outcomes.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable Codes: 20605, 20606, 20611, 21010, 21050, 21060, 21070, 21073, 21089, 21240, 21242, 21243, 29800, 29804, 21116

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient.
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documentation unless all specific information needed to make a medical necessity determination is included.

In addition to medical records, a letter of medical necessity is required for all requests for TMJ surgery and should include a detailed history of the condition, diagnostic imaging results and documentation of prior medical and surgical treatment.

Scientific Background and Reference Sources

**From policy entitled: Temporomandibular Joint Dysfunction (TMJD) Treatment**

Guidelines for Diagnosis and Management of Disorders involving the Temporomandibular joint and related musculoskeletal structures, Am Soc TMJ surgeons and Am Soc of Maxillofac Surg, 1992

AAOMS Parameters of Care, Temporomandibular Joint Surgery, AM Assoc Of Oral and Maxillofacial Surgeons, 1995


Oral Surgery Consultant Panel - 10/99


BCBSA Medical Policy Reference Manual - Review date 4/15/02 - Policy 2.01.21

BCBSA Medical Policy Reference Manual - Review date 4/29/03 - Policy 2.01.21


Temporomandibular Joint Dysfunction (TMJD)


Policy retitled: Temporomandibular Joint Dysfunction


Specialty Matched Consultant Advisory Panel 10/2012


Specialty Matched Consultant Advisory Panel. 10/2014

Medical Director Review 10/2014


Specialty Matched Consultant Advisory Panel 10/2015

Medical Director Review 10/2015


Policy Implementation/Update Information

From policy entitled: Temporomandibular Joint Dysfunction (TMJD) Treatment

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/96</td>
<td>Original policy issued</td>
</tr>
<tr>
<td>8/99</td>
<td>Adjustments in Range of Motion of the TMJ. Arthroscopy of TMJ policy archived.</td>
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</tbody>
</table>
Temporomandibular Joint Dysfunction (TMJD)

9/99  Reformatted, Description of Procedure or Service changed, Medical Term Definitions added.

10/00  Oral Surgery Consultant Panel

12/99  Medical Policy Advisory Group

10/00  System coding changes.

11/00  Phrase "unless contraindicated" added concerning physical therapy under When TMJ Dysfunction is covered in the TMJ surgery section. Criteria renumbered for clarity in the Short term physical therapy and occlusal splints section of when TMJ is covered.

5/01  Specialty Matched Consultant Advisory Panel review (5/2001). No change to policy.


6/2/05  Specialty Matched Consultant Advisory Panel review - 5/13/05. No changes to criteria.

4/10/06  Added CPT code 21010 to Billing/Coding section.

6/5/06  Additional information added to "Description" section. Under "When Covered", added: (C.4.a&b.) Arthroplasty with total prosthetic joint replacement using the TMJ Concepts Patient-Fitted TMJ Reconstruction Prosthesis™. This procedure is indicated for reconstruction of the TMJ for treatment of end-stage TMJ disease, when no other viable therapeutic alternatives are available. a.) Patients should be considered if they have one or more of the following conditions: Inflammatory arthritis involving the TMJ not responsive to other modalities of treatment, recurrent fibrous and/or bony ankylosis not responsive to other modalities of treatment, failed tissue graft, failed alloplastic joint reconstruction, loss of vertical mandibular height and/or occlusal relationship due to bone resorption, trauma, developmental abnormality, or pathologic lesion. b.) Total prosthetic joint replacement should not be used for patients with one or more of the following conditions: Active or suspected infections in or about the implantation site, uncontrollable masticatory muscle hyperfunction (clenching or grinding) which may lead to overload and loosening of screws, known allergy to any of the component materials. (F. Arthrocentesis) reworded: "For the intent of this policy, arthrocentesis for closed [jaw] lock (disc displacement without reduction) is considered advanced conservative management rather than a surgical procedure, and does not need to meet the criteria above." Under "When not Covered", added total joint replacement with the TMJ Fossa-Eminence/Condylar Prosthesis System™ or partial joint replacement with the TMJ Fossa-Eminence Prosthesis™ are not covered. Both devices are considered investigational and BCBSNC does not cover investigational services. Under "Policy Guidelines", added: "At the present time, there is insufficient evidence in the published medical literature to demonstrate the safety, efficacy and long-term outcomes of the TMJ Fossa-Eminence/Condylar Prosthesis System™ for total joint replacement or the TMJ Fossa-Eminence Prosthesis™ for partial joint replacement. (Refer to separate policy number MED1263, Investigational (Experimental) Services.)". Under Billing/Coding/Physician Documentation, added: "In addition to medical records, a letter of medical necessity is required for all requests for TMJ surgery and should include a detailed history of the condition, diagnostic imaging results and documentation of prior medical and surgical treatment." Key words, medical term definitions and reference sources added. Notification given 6/5/06. Effective date 8/7/06. (pmo)
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6/18/07 Specialty Matched Consultant Advisory Panel review. No changes to criteria. Reference source added. (pmo)

12/31/07 Under "When Covered" added "Therapeutic manipulation of the TMJ requiring anesthesia (i.e., general or monitored anesthesia care) is covered for reduction of fracture or dislocation of the TMJ. Other indications will be reviewed on an individual consideration basis." Under "Billing/Coding" added new CPT code 21073 effective January 1, 2008. (pmo)

See Also: Orthognathic Surgery Policy

Policy retitled: Temporomandibular Joint Dysfunction (TMJD)

6/22/10 Policy Number(s) removed (amw)

10/26/10 CPT code 21116 (injection procedure for TMJ arthrography) added to "Billing/Coding" section. Additional information added to the Description section. Under “When Covered” Section B: MRI is considered medically necessary changed to may be considered medically necessary; Section C. TMJ Surgery added pharmacological treatment to criteria for medical necessity; Section D. Added arthroscopic coverage criteria. Under “When Not Covered” added Acupuncture as not covered/investigational. Also added Arthroscopy of the TMJ for purely diagnostic purposes is not covered. Specialty Matched Consultant Advisory Panel 1/2010. Reviewed with Senior Medical Director 8/2010. References added. (lpr)


11/12/13 Specialty Matched Consultant Advisory panel review 10/21/2013. No changes to policy statement. (lpr)

9/9/14 Reference added. No changes to policy statement. (lpr)


12/30/14 Added CPT codes 20606 and 20611 to the Billing/Coding section effective 1/1/15. (td)
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<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>10/15</td>
<td>Description section updated. References updated. Policy intent remains the same. (td)</td>
</tr>
<tr>
<td>8/30/16</td>
<td>When Covered and Not Covered sections reformatted. Added the following to the When TMJD is Covered section, item B: non-surgical treatments “Short term physical therapy [is covered] when administered by a licensed physical therapist.” (an)</td>
</tr>
<tr>
<td>9/20/16</td>
<td>Item 3 in the non-covered section updated to include an additional investigational treatment. Statement now reads: The following non-surgical treatments are considered investigational in the treatment of TMJ dysfunction: Alpha-Stim. Added CPT code 21089. (an)</td>
</tr>
<tr>
<td>11/22/16</td>
<td>Specialty Matched Consultant Advisory Panel review 10/26/2016. No change to policy statement. (an)</td>
</tr>
<tr>
<td>1/27/17</td>
<td>Added trigger point/tender point injections to the list of investigational, non-surgical treatment for TMJ. Updated Policy Guidelines section. (an)</td>
</tr>
</tbody>
</table>

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.