



Surgical Treatment of TMJ Disorders

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Policy

The Management Department reviews referral requests for authorization of surgical treatment of TMJ. Non-surgical treatment does not require prior authorization.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

Documentation Required:

In order to facilitate the authorization process referral requests must include **ALL** the following:

1. Clinical evaluation of patient's diagnosis and symptoms; including duration of symptoms, evidence of pain or functional disability by an intra-capsular condition (condyles).
2. Diagnostic imaging studies indicating the presence of joint pathology.
3. Documentation of no response to six (6) months of non-surgical therapy which includes at least **ONE** of the following:
 - a) Manipulation; **OR**
 - b) One of the following reversible intra-oral appliances:
 - i. an anterior positioning appliance, **OR**
 - ii. a stabilization splint; **AND****ONE** of the physical therapy treatments below:
 1. Physical therapy
 - a. Active OR passive range of motion (ROM); **OR**
 - b. Application of heat and/or ice
 2. Pharmacological therapy:
 - a. Nonsteroidal anti-inflammatory drugs (NSAIDs); **OR**
 - b. Muscle relaxants; **OR**
 - d. Low dose antidepressants; **OR**
 3. Behavioral therapy:
 - a. Cognitive; **OR**
 - b. Behavioral; **OR**
 - c. Relaxation therapy.
4. The procedure or device is to control or eliminate infection, pain, disease or dysfunction.

B. Criteria for Medical Necessity:

Therapeutic arthroscopy, arthrocentesis, condylotomy/eminectomy, modified condylotomy, arthroplasty, or TMJ reconstruction using autogenous or alloplastic materials are surgical procedures considered to be medically necessary to correct TMJ pain or TMJ functional disability if **ONE** of the following criteria are met:

NOTE: The least invasive appropriate surgical procedure should be attempted prior to progression to a more complicated surgery.

1. TMJ Arthrocentesis

Arthrocentesis is medically necessary for lysis of adhesions, insufflation of joint space and infusion of medications when imaging and clinical documentation identifies **ONE** of the following:

- a. Anchored disc phenomenon; **OR**
- b. Anterior disc displacement w/o reduction and no effusion noted; **OR**
- c. Osteoarthritis w/o fibrosis or loose bone particles; **OR**
- d. Hemarthrosis; **OR**
- e. "Open lock" condition (condyle is entrapped in front of disc and cannot slide back under the fossa).

2. TMJ Arthroscopy

Therapeutic arthroscopy is medically necessary when an MRI/CT confirms adhesions, fibrosis, DJD or internal derangement of disc requiring internal modification.

3. TMJ Arthroplasty or TMJ Arthrotomy

Arthroplasty or arthrotomy is considered medically necessary when **BOTH** the following are met:

- a. MRI/CT confirms one of the following: osteoarthritis/osteoarthrosis; severed disc displacement associated with degenerated changes or perforation; or scarring is severe from prior surgeries; **AND**
- b. Surgeries may include but not limited to: disk repair; discectomy with or w/o replacement; or articular surface contouring (condylectomy or eminectomy or eminoplasty).

4. An open surgical procedure related to meniscus or disc repositioning/repair, or a disc removal with or without replacement is considered medically necessary when **ONE** of the following are met:

- a. It is the result of a congenital anomaly, trauma, disease, **OR**
- b. When patients have failed nonsurgical management.

5. TMJ replacement surgery utilizing an FDA approved prosthesis is considered medically necessary when **ALL** of the following are met:

- a. Conservative management has failed; **AND**
- b. Other surgical treatment has been unsuccessful; **AND**
- c. It is considered as a "salvage device" treatment for end-stage TMJ disease (FDA approved prosthesis); **AND**
- d. MRI or other imaging supports **ONE** of the following criteria:
 1. The temporal bone no longer provides a smooth articular fossa; **OR**
 2. Condyles are no longer ball-shaped; **OR**
 3. Persistent, stable inflammatory arthritis not responsive to other modalities of treatment (conservative management); **OR**
 4. Recurrent fibrous or bony ankylosis not responsive to other modalities of treatment; **OR**
 5. Mandibular condyle has lost height and/or occlusal relationship from trauma, pathological lesion, congenital anomaly, resorption; **OR**

6. Failed autologous bone graft or alloplastic reconstructive treatment.

NOTE: FDA approved TMJ prosthesis/implants include: TMJ Concepts, Christensen TMJ Fossa-Eminence Prosthesis System (partial TMJ prosthesis), Christensen TMJ Fossa-Eminence/Condylar Prosthesis System (total joint prosthesis) or W. Lorenz TMJ prosthesis for “salvage devices”.

6. **An Autogenous graft** is considered medically necessary if **ONE** of the following are met:

- a. The criteria above in #3 arthroplasty/arthrotomy is met; **OR**
- b. There is congenital absence/ deformity of the joint requiring surgical reconstruction post head and neck tumor resection.

C. Indications Considered Experimental, Investigational or not Medically Necessary: *(Not all-inclusive)*

1. TMJ arthroplasty implants that are not FDA approved.
2. Use of a continuous passive motion (CPM) device.
3. Dry needling.
4. Ketamine (local/intra-articular administration), platelet rich plasma, or hyaluronic acid (viscosupplementation).
5. Orthognathic surgery when non-related TMJ.
6. Therabite Jaw Motion Rehabilitation system.
7. Use of a TENS unit.
8. Radiofrequency generator thermolysis.

REFERENCES:

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Wisconsin State Legislature, Chapter 609; Section 609.78 Coverage of treatment for the correction of temporomandibular disorders. Section 632.895(11) Mandatory coverage. Treatment for the Correction of Temporomandibular Disorders.