A. Documentation Required:
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. Opiates; OR
         c. 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 ONE of the following are met:
   a. Imaging and clinical documentation identifies 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. Hemoarthrosis; 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.

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; diskectomy 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 a FDA approved prosthesis is considered medically necessary when ALL 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

   **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:


CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 150.1 – Treatment of Temporomandibular Joint (TMJ) Syndrome (Rev. 1. 10-01-03).


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.