Quartz

Surgical Treatment of TMJ Disorders

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

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