MEDICAL POLICY

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Medical Policy Title	**Temporomandibular Joint Disorders (TMJD)**
Policy Number	**11.01.17**
Current Effective Date	**February 15, 2027**
Next Review Date	**October 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

Services related to myofascial pain dysfunction (MPD) are not addressed in this policy as they are rendered by a dentist and considered a dental benefit, rather than a medical benefit.

POLICY STATEMENT(S)

I. Non-surgical intervention (e.g. oral appliances) for the treatment of temporomandibular joint disorder is considered **medically appropriate** when **ALL** of the following criteria (P.S. A. B. C. and D.) are met:

A. **ONE (1)** of the following definitions of functional deficit is documented:

1. Presence of pain or other physical deficit that interferes with activities of daily living; or
2. Impaired physical activity (e.g., loss of range of motion);

AND

B. Documentation demonstrates that conservative treatments have been exhausted, with a minimum of six (6) weeks of failed therapy, including dates and duration for **TWO (2) or MORE** of the following*:

1. Medication (e.g., NSAIDS, muscle relaxants or antidepressants);
2. Corticosteroid Injection;
3. Dietary modifications such as a soft diet;
4. Behavioral therapy; or
5. Physical therapy;

*Conservative therapy documentation is not required in the setting of recent trauma, dislocation, severe malocclusion, dental infection or abscess.

AND

C. Documentation includes reports from Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) of the TMJ;

AND

D. The specific documentation requirements for the requested non-surgical treatment are met:
   1. Imaging reports confirm **any** of the following:
      a. anterior disc displacement with or without reduction;
      b. disc adhesions;
      c. synovitis/capsulitis;
      d. degenerative osteoarthritis;
      e. internal derangement;
      f. degenerative joint disease;
      g. rheumatoid arthritis;
      h. infectious arthritis;
      i. mandibular dislocation;
      j. neoplasia;
      k. ankylosis;
      l. condylar hyper-or hypoplasia; **or**
      m. condylar osteolysis

II. Surgical intervention for the treatment of temporomandibular joint disorder is considered **medically appropriate** when **ALL** of the following criteria (P.S. A. B. C. and D.) are met:

A. **ONE (1)** of the following definitions of functional deficit is documented:
   1. Presence of pain or other physical deficit that interferes with activities of daily living; or
   2. Impaired physical activity (e.g., loss of range of motion);

AND

B. Documentation demonstrates that conservative treatments have been exhausted, with a minimum of six (6) weeks of failed therapy, including dates and duration for **TWO (2) or MORE** of the following*:
   1. Medication (e.g., NSAIDS, muscle relaxants or antidepressants);
   2. Corticosteroid Injection;
   3. Dietary modifications such as a soft diet;
   4. Behavioral therapy; or
   5. Physical therapy;

*Conservative therapy documentation is not required in the setting of recent trauma, dislocation, severe malocclusion, dental infection or abscess.

AND

C. Documentation includes reports from Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) of the TMJ;

AND

D. The specific documentation requirements for the requested surgery type are met:

1. Arthrocentesis, Arthroscopic Lysis and Lavage, or Operative Arthroscopy (CPT 20605, 20606, 29804)
    a. Imaging reports confirm **any** of the following:
        i. anterior disc displacement with or without reduction;
        ii. disc adhesions;
        iii. synovitis/capsulitis; **or**
        iv. degenerative osteoarthritis; **and**
    b. Physical exam findings are supportive of diagnosis;
2. Open Joint Surgeries (e.g., Arthroplasty or arthrotomy, disc repair procedures, discectomy with or without replacement, condylectomy, discoplasty/disc plication, discectomy/meniscectomy) (CPT 21010, 21050, 21060, 21070, 21240, 21242)
    a. Persistent pain despite previous arthroscopic surgery; **and**
    b. Imaging reports confirm **any** of the following:
        i. internal derangement;
        ii. degenerative joint disease;
        iii. rheumatoid arthritis;
        iv. infectious arthritis;
        v. mandibular dislocation;
        vi. neoplasia;
        vii. ankylosis;
        viii. condylar hyper-or hypoplasia;
        ix. condylar osteolysis; **or**
        x. fracture;
3. Temporomandibular Joint Replacement (CPT 21243):
    a. Imaging reports demonstrate an alteration and degeneration of joint structures at both the bone (e.g., osteophytes, geodes, subchondral cysts) and disc level;

b. Reduced oral aperture (less than 35mm); **and**

c. Prior surgeries (i.e., arthroscopy or open) have failed.

Device Repair

III. Repair of a medically necessary [device] or components not under warranty will be considered **medically appropriate** when the following criteria are met:

A. Physician documentation includes **ALL** of the following:

1. date of device implantation/initiation;
2. manufacturer warranty information, if applicable;
3. attestation that the patient has been compliant with the use of device and will continue to benefit from the use of device;

B. The device is no longer functioning adequately; and **BOTH** of the following criteria are met:

1. inadequate function interferes with activities of daily living; **and**
2. repair is expected to make the equipment fully functional (as defined by manufacturer).

IV. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

Device Replacement

V. Replacement of a medically necessary [device] or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

A. The device is no longer functioning adequately and has been determined to be non-repairable, or the cost of the repair is in excess of the replacement cost;

B. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.

VI. The replacement of a properly functioning [device], its components or accessories is considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or in order to make the device more aesthetically pleasing;

VII. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

VIII. Accessories or components for [device] that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

RELATED POLICIES

Corporate Medical Policy

1.01.02 Continuous Passive Motion Device in the Home Setting

1.01.07 Medical Management of Obstructive Sleep Apnea

1.01.61 Non-Invasive Surface Electrical Stimulation for Pain and Rehabilitation

7.01.41 Surgical Management of Sleep Disorders

7.01.101 Balloon Dilation of the Eustachian Tube (BDET)

8.01.10 Prolotherapy

8.01.24 Therapies (Speech, Physical and Occupational)

11.01.03 Experimental or Investigational Services

Pharmacy Policy

Botulinum Toxin (Botox, Daxxify, Dysport, Myobloc, Xeoman)- Pharmacy 77

Viscosupplementation with Hyaluronic Acid- Pharmacy 75

POLICY GUIDELINE(S)

I. Coverage for dental-related services is **not** generally provided under medical contracts.

II. Coverage for all TMJD-related services, devices or appliances related to TMJD is contract dependent.

DESCRIPTION

The temporomandibular joint (TMJ) connects the jawbone to the skull, acting like a sliding hinge on either side of the skull. There are more than 30 conditions that cause pain and dysfunction in the jaw joint and the associated muscles that allow for movement. TMJ disorders specifically are broken into three different classes: myofascial pain-dysfunction (MPD) syndrome, internal derangement, and degenerative joint disease (DJD); however, diagnostic criteria are based on subjective findings and patients can fall into more than one class. The U.S. National Institutes of Health acknowledged in 2017 that there are no widely accepted standard tests to correctly diagnosis TMJ disorders.

MPD is considered the most common cause of TMJ pain and is thought to be a psychophysiologic disease that primarily involves the muscles of mastication. Services to treat MPD are rendered by a dentist, and are therefore not addressed within this policy.

Internal derangement is defined as an abnormal relationship of the articular disc to the mandibular condyle, fossa, and articular eminence. The muscle spasm seen in this condition is in response to the dysfunction; spasm is not the primary problem, as with MPD.

DJD (osteoarthritis) is the organic degeneration of the articular surfaces within the TMJ. It is secondary to micro/macro trauma, infection, and meniscal malalignment.

Diagnosis is typically one of exclusion and requires a combination of physical exam, patient interview, and a review of dental records. Generally, diagnostic testing or imaging are reserved for patients with severe or chronic symptoms.

Patients may experience some or even all of the following symptoms: headaches (over the eye, in the temples, behind the eyes, and at the base of the skull); general facial pain, and more specific pain directly in front of the ears; ear symptoms, including ringing, buzzing, and congestion; neck and shoulder pain; clicking or grating noises of the joint with movement; locking of the jaw; and pain with function. In severe cases, there can be functional disability, malnutrition, or airway compromise.

The main goals of treatment of TMJ disorder are to reduce or eliminate pain or joint noises, or both, and to restore normal mandibular function. TMJ disorder is a complex disorder with treatment of dependent upon identification of contributing conditions and behaviors, with first-line treatments being conservative in nature due to their low risk of potential side effects.

Arthrocentesis, Arthroscopic Lysis and Lavage

Arthrocentesis is considered a simple, minimally invasive surgery, where the joint space is not viewed, but rather incorporates the use of needles and irrigation to remove inflammatory causes of joint pain and/or to increase the mobility of the mandible by hydraulically removing present adhesions.

Operative Arthroscopy

Arthroscopy of the TMJ is a minimally invasive surgery performed under local anesthesia with sedation or general anesthesia. The joint space is viewed via fiber-optic camera (arthroscope) to diagnose and treat joint problems. The incision is small, and repairs are conducted utilizing thin surgical instruments.

Open Joint Surgeries

Open joint surgery requires a cut to be made in front of the ear, sometimes extending into the hairline to fully expose the jaw joint. It is typically used when needing to alter the shape of the joint (arthroplasty), when minimally invasive surgery was ineffective or for more advanced disease. Open surgery has an increased risk of causing damage to facial nerves and issues with hearing given the proximity to the joint.

Replacement of the Temporomandibular Joint (TMJ)

When conservative therapies have failed, it may be necessary to improve the function of a damaged joint by replacing the bone with a prosthetic. Today's U.S. Food and Drug Administration (FDA) approved joint prosthetics can be stock or custom made. The lower jaw portion of the prosthetic are typically manufactured from metal such as titanium, while the upper jaw portion of the prosthetic is made with ultra-high molecular-weight polyethylene either with or without titanium. Replacement of the TMJ is an open surgery with incisions required in front of the ear, extending to the hairline as well as below the jaw. It is also not without risk, including heterotropic ossification, infection, and chronic post-operative pain.

SUPPORTIVE LITERATURE

Non-Surgical Treatments

Yao et al (2023) conducted a systematic review and meta-analysis of randomized trials in an attempt to provide evidence-based guidelines for adult patients living with moderate chronic pain (4-6cm on a 10cm pain scale for greater than or equal to three months duration) secondary to TMD. This evidence was summarized into a recommendation by Busse et al (2023). The recommendation notes the necessity of the review given the number of interventions available for treatment, that individuals may be exposed to simple, conservative, and inexpensive treatments while others with similar sets of symptoms will be exposed to potentially invasive, irreversible, and costly treatments. As a result of the review, and the limited available evidence, the panel was only able to state confidence regarding the benefits of cognitive behavioral therapy augmented with relaxation or biofeedback, therapist-assisted jaw mobilization, and manual trigger point therapy for reduction in chronic pain severity related to TMJD (GRADE moderate to high certainty of evidence).

Surgical Treatments

Arthrocentesis of the TMJ was introduced in 1991 by Nitzan et al and its use for pain control has been supported by multiple randomized controlled trials (RCTs), systematic reviews of RCTs, as well as observational studies. (e.g., Grossman (2012), Kaneyama et al (2004), Nitzan et al (2001), Emshoff (2005), Carvajal et al (2000), Alpaslan (2003), Frost et al (2012)).

Thorpe et al (2023) conducted a systematic review comparing arthrocentesis versus conservative treatments for TMJD by focusing on joint pain and mouth opening at six months following the intervention. Studies included in the review were required to meet the following criteria: prospective randomized controlled trial conducted on humans, patients had a history of reduced mouth opening and pain, study included at least one group treated with arthrocentesis and one undergoing conservative therapies, and patients were assessed both preoperatively at recalls for maximum mouth opening and presence of pain with pain assessed via visual analogue scale and allocation being conducted on a per-patient basis. The initial search provided 879 records, with 12 articles selected for full-text analysis, with only seven meeting inclusion criteria. A total of 489 patients were represented in the studies, 448 of which were assessed at the 6-month recall mark. A bias analysis demonstrated that only one study was at low risk of bias. A random-effects model was used for the meta-analysis. Based upon the analysis, authors concluded a statistically significant superiority for arthrocentesis in the improvement of maximal mouth opening and borderline statistical superiority for pain improvement at six-months but note that the confidence interval for pain reduction crossed over zero and that the marginal differences are unlikely to be clinically relevant. Additionally, there was no conservative treatment to be found superior to another.

Tang and colleagues (2025) conducted a systematic review with meta-analysis and trial sequential to compare arthrocentesis to conservative treatments for symptomatic TMJ with short, intermediate, and long-term outcomes of objective measurements, including maximum mouth opening, joint blocks and noises, protrusive and lateral mandibular movements and cost, as well as subjective measurements of joint pain, mandibular function and quality of life (QOL). The intervention group

included TMJ arthrocentesis via any technique, with or without concomitant therapies or injections. The control group only consisted of conservative treatments of any kind. The primary study outcome was pain using a numeric scale. Only RCTs, prospective non-randomized controlled trials and retrospective cohort studies with a control group were allowed for inclusion, which resulted in 21 records suitable for inclusion. Of those 21 records, 16 were included in the qualitative and meta-analyses and five were included for the qualitative analyses only. For the primary outcome, for pain reduction, arthrocentesis was superior to conservative therapy in terms of pain reduction at both short (1-3 months) and intermediate (6-12 months) follow up. Only one RCT reported on pain reduction of long-term follow up (median 6.2 years), Tang et al (2023), which found arthrocentesis was more effective in pain reduction (-10.23 [95% CI -17.86;-2.60], p= 0.009) when compared to conservative treatments. For secondary outcomes, in regard to maximum mouth opening, 11 of 15 studies included in the quantitative analysis demonstrated improvement over time in both the arthrocentesis and conservative treatment groups, while five showed improvements in only the arthrocentesis group. One study demonstrated no statistically significant improvement over time in both groups, with two not adequately reporting differences between pre-and post-operative analysis. Studies assessing outcomes of joint pain at rest, mandibular function, joint bocks and noises, lateral and protrusive movements quality of life and cost were considered too heterogeneous to include in a meta-analysis, but authors concluded that there is a general trend of an equal or superior effect of arthrocentesis when compared to conservative therapies.

Almeida and colleagues (2025) conducted a systematic review to evaluate the long-term quality of life (QOL) outcomes after TMJ replacement, focusing on functional impairment, complication profiles, and differences between custom and stock prosthesis across both adult and pediatric populations. Eligibility criteria included patients undergoing TMJ replacement for end-stage disease (e.g., osteoarthritis, rheumatoid arthritis, juvenile idiopathic arthritis, trauma, ankylosis, condylar resorption, neoplasm). Authors included studies with or without comparator groups as well as any of the following: pre- versus postoperative outcomes, stock versus custom device, or replacement versus other surgical treatment options. Pain reduction (measured by VAS score), functional recovery (measured by maximum interincisal opening [MIO]) and QOL were primary outcomes. Complication rates and the use of advanced technologies were secondary outcomes. Included in the review were randomized controlled trials (RCTs), prospective and retrospective cohort studies and case series with more than five patients. Two reviewers independently conducted a search and out of 950 identified records, 64 were included for qualitative synthesis, representing anywhere from five to 1,262 patients. Follow-up periods expanded across six months to over 20 years. Authors reported that TMJ replacement resulted in significant improvements in patient-reported QOL assessed via the SF-36 Health Survey; TMJ-specific patient reported outcome measures, narrative satisfaction reports or structured interviews, reduced pain and disability, improved chewing, speech and diet, enhanced social confidence, sleep quality, and emotional wellbeing. The mean gain of MIO was 26-36 mm, with studies reporting 75-85% reduction in VAS scores (which was consistent between stock and custom prosthesis groups). Regarding complications, an approximate 20% of individuals developed heterotrophic ossification but authors note that when autologous fat grafting was used the rate dropped to below 5%. Infections of the prosthetic were seen in 3-4.9% of cases, Mechanical failure or loosening in roughly 4-5%, chronic pain in 20-30% of cases (often due to central sensitization)

and transient facial nerve injury in approximately 10% of cases. Permanent nerve injury occurred in 1-2% of cases. The use of custom prosthetics resulted in slightly higher MIO scores and fit for complex or revision cases while stock prostheses were comparable in pain reduction, QOL, and overall satisfaction in routine cases. Authors reviewed outcomes of pediatric TMJR reporting that there was no clear evidence of mandibular growth inhibition during 2-8 years of follow-up with significant gains in function, chewing, speech and psychosocial well-being identified. The authors conclude that this systematic review demonstrates TMJ replacement as a highly effective, safe, and durable treatment for end-stage TMJ disorders, which has been noted to consistently provide pain relief, functional improvement, and improved quality of life across varied indications, and across varying populations.

In 2023, the National Institute of Dental and Craniofacial Research (NIDCR), a division of the U.S. National Institute of Health (NIH) called attention to the gaps that remain in understanding the underlying mechanisms of TMJ, and the impact on medical and dental professionals by issuing a notice of funding opportunity to develop a future interdisciplinary research initiative. The goal of the initiative was to improve the prevention, diagnosis, and treatment of temporomandibular disorders (TMD). Nine grants totaling $2.8 million were awarded to begin planning the creation of the TMD Collaborative for Improving Patient-Centered Translational Research (TMD IMPACT). Applications to join the collaboration by higher education institutions, for-profit organizations, non-profit organizations, local and federal governments were accepted through January 2025.

PROFESSIONAL GUIDELINE(S)

In 2018, the American Association of Oral and Maxillofacial Surgeons (AAOMS) published guidelines to evaluate the impairment of the oral and maxillofacial region, including assessment of the temporomandibular joint for permanent impairment using the measurement of the voluntary, non-painful interincisal opening between maxillary and mandibular central incisors to determine the interincisal range of motion, followed by measuring the lateral excursive distance of the mandible, using the dental midlines from maximum dental intercuspation. Adding the values for loss of impairment values of interincisal opening and lateral excursive distance provides the craniomandibular articulation impairment.

In 2024, AAOMS issued a statement about the management of selected clinical conditions and associated clinical procedures for temporomandibular disorders, which includes the diagnostic assessment of TMJ disorders. The statement identifies TMJ disorders being the result of internal derangement, degenerative joint disease, rheumatoid arthritis, infectious arthritis, mandibular dislocation, neoplasia, ankylosis, condylar hyper-or hypoplasia, condylar osteolysis and fractures. Patient historical and physical findings include; unilateral or bilateral pain with or without popping or crepitus, is usually continuous or intermittent and increases with function, is localized to the joint. The mandible can have hypo-or hypermobility. AAOMS includes a history, screening and physical, imaging (e.g., plain, or tomographic TMJ radiographs, CT, MRI, three-dimensional imaging), appropriate laboratory testing such as a rheumatoid panel and initiating the least invasive therapy for treatment. The guidelines suggest that non-surgical management includes "medication (e.g., NSAIDs), orthotic appliance, and physical therapy", while surgical treatments include "manipulation

under anesthesia, arthrocentesis, non-arthroscopic lysis and lavage, arthroscopic surgery, open arthroplasty with or without autograft, open arthroplasty with alloplast, disc repair or removal (with or without replacement), coronoidectomy, condylectomy, mandibular condylotomy, myotomy, orthognathic surgery, partial or total reconstruction". The therapeutic outcomes include "a level of pain that is of little or no concern to the patient, improved jaw function, improved ability to masticate food, functional and stable occlusion, limited period of disability, acceptable clinical appearance, absence of recurrent jaw locking or dislocation, limited progression of the disease, and in growing children, continued symmetrical growth of the mandible in proper relationship to the midface."

The American Society of Temporomandibular Surgeons (ASTMJS) is a non-profit organization comprised of maxillofacial, orthopedic, plastic/reconstructive, and oral surgical specialists. The ASTMJS website (2025) includes parameters and guidelines for treatment, stating the following "In the United States, the NIH has estimated that 10 million Americans have painful TMJ dysfunction, the majority of which are self-limiting or respond to non-surgical treatment. As in orthopedic management of other joint systems of the body, anti-inflammatory medication, physical therapy, orthotics or splints, and rest are usually sufficient initial treatment modalities. However, the time given to initial treatment must be finite when such treatment proves to be ineffective, or the clinical condition deteriorates. Surgical procedures are indicated when pre-surgical imaging studies confirm pathologic and structural changes of the joint that creates significant pain dysfunction and impairment."

For more information, refer to the ASTMJS website, available from: https://astmjs.org/tmd-general-information/ [accessed 2026 Jul 26].

REGULATORY STATUS

The United States Food and Drug Administration (FDA) regulates temporomandibular joint prosthetics as medical devices. All TMJ prosthetics require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2026 Jul 27]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most serious type of recalls. Available from: Medical Device Recalls | FDA [accessed 2026 Jul 27]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or burse (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa); without ultrasound guidance
20606	with ultrasound guidance, with permanent recording and reporting
21010	Arthrotomy, temporomandibular joint
21050	Condylectomy, temporomandibular joint (separate procedure)
21060	Meniscectomy, partial or complete, temporomandibular joint
21070	Coronoidectomy (separate procedure)
21073	Manipulation of the temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	Arthroplasty, temporomandibular joint, with allograft
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21299	Unlisted craniofacial and maxillofacial procedure
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	Open treatment of temporomandibular dislocation
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804	Arthroscopy, temporomandibular joint, surgical

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HCPCS Codes

Code	Description
Not Applicable	

CDT Codes

Code	Description
D0320	Temporomandibular joint arthrogram, including injection
D0321	Other temporomandibular joint radiographic images, by report
D7810-D7880	Reduction of dislocation and management of other temporomandibular joint dysfunctions (code range)

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ICD10 Codes

Code	Description
M26.60-M26.69	Disorders of temporomandibular joint (code range)

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Temporomandibular joint dysfunction is not addressed in National or Regional Medicare coverage determinations or policies. However, treatment of TMJ syndrome is addressed in the chapter addressing Covered Medical and Other Health Services, Section 150.1, in the Medicare Benefit Policy Manual. Please refer to the following website for Medicare members:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf [accessed 2026 Jul 27].

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

06/23/05, 04/27/06, 02/22/07, 12/31/07, 12/11/08, 12/10/09, 12/09/10, 12/08/11, 12/06/12, 12/12/13, 12/11/14, 12/10/15, 12/08/16, 12/14/17, 12/13/18, 12/12/19, 12/10/20, 12/16/21, 12/22/22, 11/16/23, 11/21/24, 01/22/26, 10/22/26

Date	Summary of Changes
10/22/26	• Off cycle review; added criteria for non-surgical management of TMJD.
01/22/26	• Annual review. Expanded conservative treatment and specific surgical treatment criteria, as well as diagnostic testing requirements. A functional deficit is required for surgical treatment of TMJ.
01/01/25	• Summary of changes tracking implemented.
06/23/05	• Original effective date