MEDICAL POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Temporomandibular Disorders - Nonsurgical Treatment-MP-MM-1418	12/01/2025 Kentucky inactive as of 01/01/2026
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Temporomandibular Disorders - Nonsurgical Treatment

B. Background

Temporomandibular disorder (TMD) refers to a group of conditions involving the orofacial region divided into those affecting the masticatory muscles and those affecting the temporomandibular joint (TMJ). Although the precise etiology of TMD is unclear, it is believed to be multifactorial. Temporomandibular disorders are often divided into 2 main categories: articular disorders and masticatory muscle disorders. These disorders are believed to be the result of either macro or micro trauma affecting the joint and/or the associated facial musculature.

The diagnosis of TMD is largely based on a clinical examination and patient symptoms survey. Symptoms attributed to TMD are varied and may include clicking sounds in the jaw, headaches, closing or locking of the jaw due to muscle spasms (trismus), a displaced disc, tinnitus, bruxism and associated pain in the ears, neck, arm, or spine. Imaging of the temporomandibular joints and associated structures may be necessary to establish the presence or absence of pathology, establish prognosis, stage disease for appropriate treatment, and assess response to therapy.

Treatment options vary depending on symptoms. Options include nonsurgical or surgical treatment. There is evidence that supports most patients improve with a combination of noninvasive therapies, patient education, self-care, cognitive behavior therapy, pharmacotherapy, physical therapy, and the use of occlusal devices. When symptoms are not resolved through noninvasive therapy, referral to an oral and maxillofacial surgeon is indicated. In a prospective controlled study, Hall et al. (2005) compared the outcomes of 4 surgical treatments (arthroscopy, condylotomy, discectomy, and disc repositioning) used for the treatment of TMD and concluded all 4 procedures were followed by marked improvements. While surgical procedures follow MCG clinical criteria, this policy discusses nonsurgical treatment guidelines.

Medically necessary services that could be performed by a qualified healthcare provider, including a dentist, are covered if performance of those services is within the scope of the dentist's license, according to state law. Therapy of TMD varies considerably according to training, discipline, and experience of the clinician.

C. Definitions

- **Arthrography** – A type of imaging used to evaluate and diagnose unexplained pain and joint conditions.
- **Articular Disorder** – TMJ disorders, including ankylosis, congenital or developmental disorders, disc derangement disorders, fractures, inflammatory disorders, osteoarthritis, and joint dislocation.
- **Bruxism** – Clenching or grinding of the teeth.
- **Masticatory Muscle Disorder** – TMJ disorders, including myofascial pain, myofibrotic contracture, myospasm, and neoplasia.

- **Physical Therapy** – Therapy as defined in this policy may include repetitive active or passive jaw exercises, thermal modalities (hot/cold packs), joint manipulation, vapor coolant spray, stretch technique, and electro-galvanic simulation.
- **Temporomandibular Joint (TMJ)** – The connecting hinge mechanism between the base of the skull (temporal bone) and the lower jaw (mandible).
- **Tinnitus** – Ringing or other noises in one or both ears.
- **Trismus** – Locking of the jaw due to muscle spasms.

D. Policy

I. Clinical Information Documentation Requirements
CareSource considers non-surgical treatment of TMD medically necessary when **ALL** the following clinical documentation criteria are included:

A. comprehensive clinical office notes identifying **ALL** the following:
1. diagnosis of a well-defined physical and/or physiological abnormality (eg, congenital abnormality, functional or skeletal impairments) resulting in a medical condition that has required or will require TMD treatment
2. notation that the documented physical and/or physiological abnormality has resulted in a functional deficit or impairment
3. notation that the functional deficit or impairment is recurrent or persistent in nature
4. notation regarding the degree to which the abnormality is causing impairment
5. documentation of prior medical and surgical treatment

B. applicable TMD radiological films and/or reports, such as AP radiograph, panoramic radiograph, CT scans and/or MRI

C. completion and results of blood tests and laboratory studies as applicable if systemic illness is suspected

D. completion and results of a psychological evaluation, if applicable

E. treating clinician's plan of care, including treatment objectives and expected outcome for the improvement of the functional deficit

II. Diagnostic Procedures
CareSource considers the following modalities medically necessary for diagnostic testing for TMD:

A. examination, including physical and psychological evaluation (as applicable)

B. imaging that may include the following:
1. radiologic examination (ie, contrast studies), but not standard dental radiographic images
2. temporomandibular joint ultrasound
3. CT/MRI scan for presurgical exam based on CareSource's vendor management requirements, which prior authorization review by CareSource's imaging management vendor and are subject to vendor review criteria.
4. Laboratory studies and blood tests may be performed if systemic illness is suspected to be the cause of the temporomandibular disorder, which may require prior authorization review by CareSource's laboratory vendor and are subject to vendor review criteria.

5. Joint arthrography may be considered when patient history and physical examination findings indicate joint trauma and/or suspected pathology and confirmation of the suspected structures involved is needed and cannot be made from standard imaging.

III. Nonsurgical Treatment

CareSource considers appliance therapy, such as an occlusal orthotic device, physical therapy, masticatory muscle and temporomandibular joint injections, and trigger point injections, as medically necessary when significant clinical symptoms and signs are present, including **at least 2** or more of the following:

A. extra-articular pain related to muscles of the head and neck region, such as earaches, headaches, masticatory, or cervical myalgias
B. painful chewing (not dental pathology related)
C. restricted range of motion, manifested by **1** of the following:
   1. interincisal opening of less than 35 mm (greatest distance between front upper teeth and lower front teeth when mouth is wide open)
   2. lateral excursive movement (side to side movement) of less than 35 mm
   3. protrusive excursive movement (front to back motion) of less than 4 mm
   4. deviation on opening of greater than 5 mm; AND symptoms are not resolved by conservative treatment, such as removal of precipitating activities (ie, gum chewing, eating hard candies), pharmacological treatment (such as anti-inflammatory or analgesic medications), or change of textural diet change

Note: Physical therapy of necessary frequency and duration may be limited to a multiple modality benefit when more than 1 therapeutic treatment is rendered on the same date of service.

IV. Exclusions

CareSource considers the following experimental and investigational for diagnosis and the nonsurgical treatment of TMD due to insufficient evidence of efficacy and, therefore, are not a covered benefit (not an all-inclusive list):

A. standard dental radiographic procedures
B. hydrotherapy (immersion therapy, whirlpool baths)
C. iontophoresis
D. orthodontic/bite adjustment services and orthodontic fixed appliances
E. biofeedback

Note: It will be determined during the Plan's prior authorization process if the nonsurgical treatment of TMD is considered medically necessary for the requested indication (and must be related to a specific medical condition).

E. State-Specific Information

NA

F. Conditions of Coverage
NA

G. Related Policies/Rules
NA

H. Review/Revision History

	DATE	ACTION
Date Issued	01/18/2023	New policy
Date Revised	12/13/2023 12/04/2024 09/10/2025	Updated references. Approved at Committee. Annual review. Updated references. Approved at Committee. Annual review. Title amended, replaced TMJD/TMJ with TMD, removed references to surgical procedures, updated references. Change physician to provider where applicable. Approved at Committee.
Date Effective	12/01/2025	
Date Archived		

I. References

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