### Policy Statement

#### Diagnostic Procedures

Any of the following diagnostic procedures may be considered medically necessary in the diagnosis of temporomandibular joint disorder (TMJD):

- Cephalograms (x-rays of jaws and skull)
- Computed tomography (CT) scan or magnetic resonance imaging (MRI) (in general, CT scans and MRIs are reserved for presurgical evaluations)
- Diagnostic x-ray, tomograms, and arthrograms
- Pantograms (x-rays of maxilla and mandible)

(Cephalograms and pantograms should be reviewed on an individual basis.)

Any of the following diagnostic procedures are considered investigational in the diagnosis of TMJD:

- Arthroscopy of the temporomandibular joint (TMJ) for purely diagnostic purposes
- Computerized mandibular scan (measures and records muscle activity related to movement and positioning of the mandible and is intended to detect deviations in occlusion and muscle spasms related to TMJD)
- Electromyography (EMG), including surface EMG
- Joint vibration analysis
- Kinesiography
- Muscle testing
- Neuromuscular junction testing
- Range-of-motion measurements
- Somatosensory testing
- Standard dental radiographic procedures
- Thermography
- Transcranial or lateral skull x-rays; intraoral tracing or gnathic arch tracing (intended to demonstrate deviations in the positioning of the jaw that are associated with TMJD)
- Ultrasound imaging/sonogram

#### Nonsurgical Treatments

Either of the following nonsurgical treatments may be considered medically necessary in the treatment of TMJD:

- Intraoral removable prosthetic devices or appliances (encompassing fabrication, insertion, adjustment)
- Pharmacologic treatment (e.g., anti-inflammatory, muscle relaxing, analgesic medications)

Any of the following nonsurgical treatments are considered investigational in the treatment of TMJD:

- Acupuncture
- Biofeedback
- Dental restorations/prostheses
- Devices promoted to maintain joint range of motion and to develop muscles involved in jaw function
- Electrogalvanic stimulation
- Hyaluronic acid (See Blue Shield of California Medication Policy)
- Iontophoresis
- Orthodontic services (See Policy Guidelines)
1. Percutaneous electrical nerve stimulation (PENS)
2. Transcutaneous electrical nerve stimulation (TENS)
3. Ultrasound

**Surgical Treatments**

Any of the following surgical treatments may be considered **medically necessary** in the treatment of TMJD:

1. Arthrocentesis
2. Arthroscopic surgery in patients with objectively demonstrated (by physical examination or imaging) internal derangements (displaced discs) or degenerative joint disease who have failed conservative treatment
3. Manipulation for reduction of fracture or dislocation of the TMJ
4. Open surgical procedures (when TMJD results from congenital anomalies, trauma, or disease in patients who have failed conservative treatment) including, but not limited to, arthroplasties; condylectomies; meniscus or disc plication, and disc removal

**Policy Guidelines**

Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for the medical treatment to alleviate TMJD is not a covered benefit per Blue Shield of California Evidence of Coverage (EOC). Refer to the subscriber's dental or orthodontia benefit for further reference.

The following diagnoses/symptoms may be associated with TMJD (list is not all inclusive):

1. Asymmetrical motor neuropathy
2. Cephalgia
3. Cervicalgia
4. Cranial-cervical syndrome
5. Localized myospasm
6. Musculoskeletal dysfunction
7. Myalgia/myositis
8. Myofascial pain/dysfunction syndrome
9. Neural entrapment

Claims may be received for psychiatric/psychological visits in relation to TMJD, as this condition may be psychosomatic in origin, resulting from tension or stress. Bruxism is a common symptom of tension, which may lead to symptoms suggestive of TMJ syndrome.

**Description**

Temporomandibular joint disorder (TMJD) refers to a group of disorders characterized by pain in the temporomandibular joint and surrounding tissues. Initial conservative therapy is generally recommended; there are also a variety of nonsurgical and surgical treatment possibilities for patients whose symptoms persist.

**Related Policies**

- Biofeedback as a Treatment of Chronic Pain
- Low-Level Laser Therapy
- Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy
- Transcutaneous Electrical Nerve Stimulation
Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

Since 1981, several muscle-monitoring devices have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process. Some examples are the K6-I Diagnostic System (Myotronics), the BioEMG III™ (Bio-Research Associates), M-Scan™ (Bio-Research Associates), and the GrindCare Measure (Medotech A/S). These devices aid clinicians in the analysis of joint sound, vibrations, and muscle contractions when diagnosing and evaluating TMJD. Food and Drug Administration product code: KZM.

Table 1. Muscle-Monitoring Devices Cleared by the U.S. Food and Drug Administration

<table>
<thead>
<tr>
<th>Devices</th>
<th>Manufacturer</th>
<th>Date Cleared</th>
<th>510(k) No.</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>K6-I Diagnostic System</td>
<td>Myotronics, Inc</td>
<td>Jun 1994</td>
<td>K922456</td>
<td>Electromyography</td>
</tr>
<tr>
<td>M-Scan™</td>
<td>Bio-Research Associates</td>
<td>Jul 2013</td>
<td>K130158</td>
<td>Electromyography</td>
</tr>
<tr>
<td>GrindCare Measure</td>
<td>Medotech A/S</td>
<td>Apr 2012</td>
<td>K113677</td>
<td>Electromyography, Nocturnal Bruxism</td>
</tr>
</tbody>
</table>

Rationale

Background

Temporomandibular Joint Disorder

TMJ D (also known as temporomandibular joint syndrome) refers to a cluster of problems associated with the temporomandibular joint and musculoskeletal structures. The etiology of TMJ D remains unclear and is believed to be multifactorial. TMJ D is often divided into two main categories: articular disorders (e.g., ankylosis, congenital or developmental disorders, disc derangement disorders, fractures, inflammatory disorders, osteoarthritis, joint dislocation) and masticatory muscle disorders (e.g., myofascial pain, myofibrotic contracture, myospasm, neoplasia).

Diagnosis

In the clinical setting, TMJ D is often a diagnosis of exclusion and involves physical examination, patient interview, and a review of dental records. Diagnostic testing and radiologic imaging are generally only recommended for patients with severe and chronic symptoms. Diagnostic criteria for TMJ D have been developed and validated for use in both clinical and research settings.1,2,3

Symptoms attributed to TMJ D vary and include, but are not limited to, clicking sounds in the jaw; headaches; closing or locking of the jaw due to muscle spasms (trismus) or displaced disc; pain in the ears, neck, arms, and spine; tinnitus; and bruxism (clenching or grinding of the teeth).
Treatment
For many patients, symptoms of TMJD are short-term and self-limiting. Conservative treatments (e.g., eating soft foods, rest, heat, ice, avoiding extreme jaw movements) and anti-inflammatory medication are recommended before considering more invasive and/or permanent therapies (e.g., surgery).

Note that low-level laser therapy for TMJD is addressed in Blue Shield of California Medical Policy: Low-Level Laser Therapy.

Literature Review
Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

For treatment of temporomandibular joint disorders (TMJD), literature searches have focused on studies comparing novel treatments with conservative interventions and/or placebo controls (rather than no-treatment control groups) and reporting pain reduction and/or functional outcome improvements (e.g., jaw movement).

Diagnosis of Temporomandibular Joint Disorder
Clinical Context and Test Purpose
TMJD (also known as temporomandibular joint syndrome) refers to a cluster of problems associated with the temporomandibular joint and musculoskeletal structures. The etiology of TMJD remains unclear and is believed to be multifactorial. TMJD is often divided into 2 main categories: articular disorders (e.g., ankylosis, congenital or developmental disorders, disc derangement disorders, fractures, inflammatory disorders, osteoarthritis, joint dislocation) and masticatory muscle disorders (e.g., myofascial pain, myofibrotic contracture, myospasm, neoplasia).

The purpose of specific diagnostic tests in patients who have suspected TMJD is to provide an option that is an alternative to or an improvement on existing diagnostic approaches, such as a comprehensive history and physical exam and alternative diagnostic tests.

The question addressed in this evidence review is: Do specific diagnostic tests improve the net health outcome for individuals with suspected TMJD?

The following PICO was used to select literature to inform this review.

Patients
The relevant population of interest is individuals with suspected TMJD.
Interventions
The diagnostic tests being considered are ultrasound, surface electromyography, and joint vibration analysis. Patients with suspected TMJD are managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting.

Comparators
Comparators of interest include a comprehensive history and physical exam and alternative diagnostic tests. Alternative diagnostic tests can include routine dental x-rays, panoramic radiographs, computed tomography, magnetic resonance imaging, and scintigraphy. Patients with suspected TMJD are managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting.

Outcomes
The general outcomes of interest are test validity and other test performance measures. The existing literature evaluating ultrasound, surface electromyography, and joint vibration analysis as diagnostic tests for suspected TMJD has varying lengths of follow-up. While studies described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, at least 1 year of follow-up is considered necessary to demonstrate efficacy.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid.

a. The study population represents the population of interest. Eligibility and selection are described.

b. The test is compared with a credible reference standard.

c. If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.

d. Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., Receiver Operating Characteristic, Area Under the Receiver Operating Curve, c-statistic, likelihood ratios) may be included but are less informative.

e. Studies should also report reclassification of diagnostic or risk category.

Several systematic reviews of the literature on specific techniques for diagnosing TMJD were identified and are described next.

Ultrasound
Almeida et al. (2019) evaluated the diagnostic efficacy of ultrasound to assess TMJDs such as disc displacement (DD), joint effusion (JE), and condylar changes, with 3D imaging as the reference standard (see Table 2). The authors identified 28 studies with a total of 2829 joints. Combined sensitivities of ultrasound for diagnosing DD, JE, and condylar changes all fell within the “acceptable” range as defined by the authors (see Table 3). “Excellent” combined specificity was reported for ultrasound to diagnose JE, but specificity for DD was in the “acceptable” range, and condylar changes specificity fell below acceptable. Heterogeneity across studies was high (I² range = 83.35–96.12), as were the ranges of sensitivity and specificity seen across studies. The variation in the sensitivity and specificity across the 3 pathologies could be related to the diagnostic parameters used to detect the TMJD, or it could be due to the different transducer frequencies used, probe design, examination methods, and skill of the sonographers and image readers. Considering the limitations and cost of magnetic resonance imaging (MRI), the lower cost, accessibility, and non-invasive and non-ionizing radiation of ultrasound make it a good screening method, especially for DD and JE. Future studies should be
conducted to determine if dynamic 3D ultrasound with high-resolution transducer increases the reliability of the examination.

Tables 2 and 3 summarize the results of the meta-analysis by Almeida et al. (2019).4

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>Participants</th>
<th>N (Range)</th>
<th>Design</th>
<th>Reference Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almeida et al.</td>
<td>1997-2016</td>
<td>28</td>
<td>Patients with suspected TMJ disc displacement, joint effusion, or condylar changes (N=1204)</td>
<td>(3-100)</td>
<td>27 cohort; 1 case-control</td>
<td>MRI or CT imaging</td>
</tr>
</tbody>
</table>

CT: computed tomography; MRI: magnetic resonance imaging; TMJ: temporomandibular joint; TMJD: temporomandibular joint disorder(s).

<table>
<thead>
<tr>
<th>Study</th>
<th>Combined Sensitivity1</th>
<th>Combined Specificity2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>95% CI, %</td>
</tr>
<tr>
<td>DD</td>
<td>70</td>
<td>70-87</td>
</tr>
<tr>
<td>JE</td>
<td>70</td>
<td>52-84</td>
</tr>
<tr>
<td>CC</td>
<td>73</td>
<td>50-88</td>
</tr>
</tbody>
</table>

CI: confidence interval; CC: condylar change; DD: disc displacement; JE: joint effusion; TMJD: temporomandibular joint disorder(s).
1 Acceptable sensitivity defined by authors as 70%-80%; excellent sensitivity as >80%.
2 Acceptable specificity defined by authors as 80%-90%; excellent specificity as >90%.

A literature review by Manfredini et al. (2009) included 20 studies evaluating ultrasound for diagnosing TMJDs; all studies evaluated disc displacement, and several also considered osteoarthrosis and/or joint effusion.5 The reported sensitivity of ultrasound to detect disc displacement, compared with the reference standard (MRI in most studies), ranged from 31% to 100%, and the specificity ranged from 30% to 100%. Reviewers stated that even when changes in ultrasound technology over time were taken into account, study findings were contradictory. They noted unexplained differences between studies conducted by the same group of researchers. Reviewers concluded that additional advances are needed to standardize the ultrasound assessment of TMJD before it can be considered an accurate diagnostic tool.

Surface Electromyography
A review on surface electromyography by Klasser et al. (2006) found a lack of literature on the accuracy of this method of diagnosis, compared with a criterion standard (i.e., comprehensive clinical examination and history-taking).6 Reviewers concluded there was insufficient evidence that electromyography can accurately distinguish people with facial pain from those without pain, but that the technique may be useful in a research setting.

Joint Vibration Analysis
Sharma et al. (2013) published a systematic review on joint vibration analysis for diagnosis of TMJDs.7 Reviewers identified 15 studies that evaluated the reliability and/or diagnostic accuracy of joint vibration analysis compared with a reference standard. Methodologic limitations were identified in all studies and included the absence of well-defined diagnostic criteria, use of a nonvalidated system for classifying disease progression, variability within studies in the reference standard used, and lack of blinding. In the 14 studies reporting on diagnostic accuracy, there was a wide range of reported values, with sensitivity ranging from 50% to 100% and specificity ranging from 59% to 100%.
Section Summary: Diagnosis of Temporomandibular Joint Disorder
Current evidence is insufficient or imprecise to support the use of ultrasound, surface electromyography, or joint vibration analysis to diagnose TMJD.

Orthotics and Pharmacologic Treatment of Temporomandibular Joint Disorder
Clinical Context and Therapy Purpose
The purpose of orthotics and pharmacologic treatment in patients with a confirmed diagnosis of TMJD is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as alternative nonsurgical intervention.

The question addressed in this evidence review is: Do orthotics and pharmacologic treatment improve the net health outcome for individuals with a confirmed diagnosis of TMJD?

The following PICO was used to select literature to inform this review.

Patients
The relevant population of interest is individuals with confirmed TMJD.

Interventions
The therapies being considered are intraoral devices or appliances and pharmacologic treatment. Intraoral devices and appliances are described in the Regulatory Status section above and can include stabilization splints. Pharmacological treatment can include nonsteroidal anti-inflammatory drugs, opioids, corticosteroids, muscle relaxants, antidepressants, anticonvulsants, and benzodiazepines.

Patients with confirmed TMJD are actively managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting.

Comparators
The main comparators of interest are alternative nonsurgical interventions, such as medications, physical therapy, and injections. Alternative medicine techniques can also be used, such as acupuncture, relaxation techniques, transcutaneous electric nerve stimulation (TENS), and biofeedback.

Outcomes
The general outcomes of interest are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Symptoms of TMJD may include pain, tenderness, or aching in the jaw or one or both of the temporomandibular joints, difficulty or pain while chewing, and locking of the temporomandibular joint.

The existing literature evaluating intraoral devices or appliances and pharmacologic treatment as a treatment for confirmed TMJD has varying lengths of follow-up, ranging from 6 weeks to 1 year. Although the systematic reviews described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, at least 1 year of follow-up is considered necessary to demonstrate efficacy.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:
   a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
   b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
   c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
   d. Studies with duplicative or overlapping populations were excluded.
Systematic Reviews
List and Axelsson (2010) published a review of systematic reviews on treatments for TMJ disorders through August 2009. They identified 30 reviews; there were 23 qualitative systematic reviews and 7 meta-analyses. Eighteen of the systematic reviews included only RCTs, 3 included only case-control studies, and 9 included a mix of RCTs and case series. TMJ disorders were defined inconsistently in the primary studies and systematic reviews, and several reviews addressed the related diagnoses of bruxism, disc replacements, and myofascial pain. Twenty-nine of the systematic reviews had pain intensity or pain reduction as the primary outcome measure, and 25 reported clinical outcome measures such as jaw movement or jaw tenderness on palpation.

Reviewers divided the treatments into 5 categories (some studies were included in >1 category). These categories and the main findings are listed in Table 4.

Table 4. Categories of Treatment

<table>
<thead>
<tr>
<th>Categories</th>
<th>No. of Articles</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occlusal appliances, occlusal adjustment, and orthodontic treatment</td>
<td>10</td>
<td>Six systematic reviews did not find significant benefit versus other treatments, 4 found no benefit versus a placebo device, and 3 found occlusal therapy was better than no treatment.</td>
</tr>
<tr>
<td>Physical treatments including acupuncture, TENS, exercise, and mobilization</td>
<td>8</td>
<td>Four reviews found no significant benefit of acupuncture over other treatments, 1 found no difference between acupuncture and placebo treatment, and 3 found acupuncture was better than no treatment. One review found active exercise and postural training were effective for treating TMJ disease-related pain.</td>
</tr>
<tr>
<td>Pharmacologic treatment</td>
<td>7</td>
<td>Treatments found to be superior to placebo were analgesics (2 reviews), clonazepam or diazepam (3 reviews), antidepressants (4 reviews), and hyaluronate (1 review). One review found effects of hyaluronate and corticosteroids to be similar.</td>
</tr>
<tr>
<td>Maxillofacial surgery</td>
<td>4</td>
<td>Three reviews evaluated surgery for patients with disc displacements and 1 addressed orthognathic surgery in patients with TMJ disease. Reviews of surgical treatments generally included lower-level evidence (eg, case series), and did not always compare surgery with a control condition. One review of patients with disc displacements with reduction reported similar treatment effects for arthrocentesis, arthroscopy, and discectomy, and another review in patients with disc displacement without reduction found similar effects of arthrocentesis, arthroscopy, and physical therapy (used as a control intervention). Due to the lack of high-quality controlled studies, conclusions could not be drawn about intervention equivalence.</td>
</tr>
<tr>
<td>Behavioral therapy and multimodal treatments</td>
<td>6</td>
<td>Two reviews found biofeedback to be better than active control or no treatment, 1 review found a combination of biofeedback and CBT to be better than no treatment, and 2 found a combination of biofeedback and relaxation to be better than no treatment. One review found the effects of biofeedback and relaxation to be similar.</td>
</tr>
</tbody>
</table>

Adapted from List and Axelsson (2010).

Overall, reviewers concluded there was insufficient evidence that electrophysical modalities and surgery would be effective for treating TMJ disorders. They found some evidence that occlusal appliances, acupuncture, behavioral therapy, jaw exercises, postural training, and some medications could be effective at reducing pain for patients with TMJ disorders. However, reviewers noted that most of the systematic reviews examined included primary studies with considerable variation in methodologic quality and, thus, it was not possible to draw definitive conclusions about the effectiveness of any of the treatments.

Randhawa et al. (2016) published a systematic review of noninvasive interventions for TMJ disorders, which included RCTs with at least 30 individuals per treatment arm, cohort studies with at least...
100 patients per exposed group, and case-control interventions.9 Reviewers identified 31 studies for appraisal, of which 7 RCTs described in 8 publications had a low risk of bias and were assessed further. Most RCTs evaluated interventions outside the scope of our review, including cognitive-behavioral therapy and self-care management. Three RCTs evaluated occlusal devices for TMJDs of variable duration and generally reported no significant improvements with occlusal devices regarding pain, mouth opening, or other outcomes.

**Orthotics**

**Intraoral Devices or Appliances**

Fricton et al. (2010) reported on a systematic review of RCTs on the intraoral treatment of TMJDs and identified 47 publications on 44 trials.10 Intraoral appliances included soft and hard stabilization appliances, posterior positioning appliances, anterior bite appliances, and soft resilient appliances. Studies compared 2 types of devices or compared 1 device with different treatments (e.g., acupuncture or biofeedback). None of the studies evaluated the use of 1 device during the day and a different device during the night. The primary outcome of the meta-analysis was pain reduction. The pain was measured differently in the studies, and reviewers defined a successful outcome as at least a 50% reduction in pain on a self-report scale or at least an “improved” status when the pain was measured by the subjective report of status. Ten RCTs were included in 2 meta-analyses; the others were excluded because they did not measure pain, there were not at least 2 studies using similar devices or control groups, or data were not usable for pooled analysis. A pooled analysis of 7 RCTs (n=385 patients) that evaluated hard stabilization appliances and use of palatal nonoccluding appliances as a control found a significantly greater reduction in pain with hard appliances (odds ratio, 2.45; 95% confidence interval [CI], 1.56 to 3.86; p<0.001). A pooled analysis of 3 studies (n=216 patients) did not find a statistically significant effect of hard appliances compared with a no-treatment control group (odds ratio, 2.14; 95% CI, 0.80 to 5.75; p=0.12).

Ivorra-Carbonell et al. (2016) reported on a systematic review of functional advancement devices for TMJD, which included systematic reviews, meta-analyses, RCTs, case-control studies, and cohort studies, assessed using PRISMA methodology.11 Reviewers included 21 articles evaluating some advancement device, considered of medium or high quality by CONSORT criteria. Results were summarized descriptively; reviewers concluded that, after treatment with mandibular advancement, the condyle was in a “more advanced position.”

**Stabilization Splints**

Ebrahim et al. (2012) identified 11 RCTs comparing splint therapy for TMJDs with minimal or no therapy.12 Nine of the 11 studies used stabilization splints, 1 used soft splints, and 1 used an anterior repositioning appliance. Reviewers used the GRADE system to rate study quality. Nine studies did not report whether allocation was concealed, and 6 studies did not report masking outcome assessors. Length of follow-up in the studies ranged from 6 to 52 weeks. A pooled analysis of study findings found that splint therapy was significantly associated with a reduction in reported pain compared with minimal or no intervention (standardized mean difference, -0.93; 95% CI, -1.33 to -0.53). Using a 100-mm visual analog scale (VAS) to measure pain, splint therapy was associated with an 11.5 mm lower mean VAS score (95% CI, -16.5 to -6.6 mm). There were no statistically significant differences between groups in quality of life or depression scores.

Zhang et al. (2016) identified 13 publications from 11 studies (N=538 patients) evaluating splint therapy for TMJDs.13 Risk of bias was high for 2 or more domains for all studies. Splint therapy group patients had greater improvements in pain control than control patients (mean difference, 2.02; 95% CI, 1.55 to 2.49; I²=0.558).

An observational study by Tonlorenzi et al. (2019) assessed 21 patients with TMJD, specifically myofascial pain, to determine the effectiveness of wearing a “high” oral splint (vs. a “low” oral splint) for 3 months while sleeping.14 Results showed a significant increase of the interocclusal
distance as measured by kinesiograph (from 0.64 ± 0.53 mm to 1.42 ± 0.76 mm; p <.001), accompanied by a reduction in pain intensity in oral and extraoral regions after the 3 months.

### Pharmacologic Treatment

In their multicenter, double-blind RCT, Isacsson et al. (2019) assessed the pain-reduction efficacy of a single-dose intra-articular injection of methylprednisolone (1 mL) to the TMJ.15 A total of 54 patients with unilateral TMJD were randomized to receive either the methylprednisolone (n=27) or saline (n=27). Pain levels at maximum jaw opening were recorded on a VAS, (1-100) before the injections and 4 weeks after. The per-protocol analysis showed VAS scores for the methylprednisolone group decreased from a mean of 61.0 (95% CI: 50.0–70.7) to 33.9 (95% CI: 21.6–46.2); the saline group VAS score decreased from a mean of 59.6 (95% CI: 50.7–65.9) to 33.9 (95% CI: 23.8–43.9). The differences in these scores were statistically insignificant (P=0.81). In addition, the methylprednisolone group experienced twice as many adverse events as the saline group.

The results of the unpublished RCT titled, “Study of Orofacial Pain and ProPRANOlol (SOPPRANO)” (2019; NCT02437383) posted on ClinicalTrials.gov evaluated the efficacy of propranolol hydrochloride extended-release versus placebo in reducing pain from TMJD.16 Two hundred patients with chronic TMJD were randomized to receive either 10 weeks of the drug (n=100) or of a placebo (n=99). The primary outcome was change in the Weekly Mean Pain Index after 9 weeks of treatment (index range 0 to 100; higher score, worse outcome). The least-squares mean of the propranolol group was -13.9 (95% CI: -17.4 to -10.5); for the placebo group it was -12.1 (95% CI: -15.5 to -8.7), a nonsignificant difference (p=.41).

Häggman-Henrikson et al. (2017) published a systematic review that included 41 RCTs assessing various pharmacologic regimens for pain from TMJ Ds or burning mouth syndrome; of these, 13 were selected for a network meta-analysis.17 Nine studies evaluated temporomandibular muscular pain, which appeared to decrease more with cyclobenzaprine than with placebo, although no specific statistics were reported. Pain reduction was also favorable for botulinum toxin and Ping-On ointment in the meta-analysis; other descriptive analyses showed a reduction of pain with nonsteroidal anti-inflammatory drugs and melatonin tablets when compared with placebo.

### Section Summary: Orthotics and Pharmacologic Treatment

Evidence evaluating the use of orthotics in the treatment of TMJD, while sometimes conflicting and inconclusive, suggests that use of orthotics reduces TMJD pain. One systematic review of intraoral appliances (44 studies) and meta-analyses of subsets of these studies found a significant benefit of intraoral appliances compared with control interventions. Other systematic reviews have found a significant benefit of several pharmacologic treatments (e.g., analgesics, muscle relaxants, and anti-inflammatory medications vs. placebo). However, 1 RCT showed no significant benefit and more adverse events with methylprednisolone. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

### Other Nonsurgical Therapies

#### Clinical Context and Therapy Purpose

The purpose of nonsurgical therapies in patients with a confirmed diagnosis of TMJD is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as alternative nonsurgical intervention.

The question addressed in this evidence review is: Do nonsurgical therapies improve the net health outcome for individuals with a confirmed diagnosis of TMJD?

The following PICO was used to select literature to inform this review.
Patients
The relevant population of interest is individuals with confirmed TMJD.

Interventions
The nonsurgical therapies being considered are acupuncture, biofeedback, TENS, orthodontic services, and hyaluronic acid (HA).

Patients with confirmed TMJD are actively managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting.

Comparators
The main comparator of interest is alternative nonsurgical intervention, such as medications. Patients with confirmed TMJD are actively managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting.

Outcomes
The general outcomes of interest are symptoms, functional outcomes, quality of life, and treatment-related morbidity. above.

The existing literature evaluating nonsurgical therapies as a treatment for confirmed TMJD has varying lengths of follow-up, ranging from 1 week to 6 months. Although the systematic reviews and RCTs described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, at least 1 year of follow-up is considered necessary to demonstrate efficacy.

Study Selection Criteria
Methodologically credible studies were selected using the principles described in the second indication.

Acupuncture
A systematic review and meta-analysis by June et al (2011) identified 7 sham-controlled randomized trials evaluating acupuncture for treating TMJD. The studies included a total of 141 patients. Sample sizes of individual studies ranged from 7 to 28 patients. Four studies used a single acupuncture session, and the other 3 used 6 to 12 sessions. All 7 studies reported a change in pain intensity as assessed by VAS. In 6 of the studies, pain intensity was measured immediately after treatment; the seventh measured pain after 16 weeks. A pooled analysis of findings from 5 studies (n=107 patients) found a statistically significant reduction in pain intensity, as measured by VAS. The pooled weighted mean difference in pain intensity was -13.63 (95% CI, -21.16 to -6.10; p<0.001). A pooled subgroup analysis of 4 studies (n=89 patients) found acupuncture to be superior to a nonpenetrating sham acupuncture (weighted mean difference = -13.73; 95% CI, -21.78 to -5.67; p<0.001). A pooled analysis of 2 studies (n=18 patients) did not find a significant difference in efficacy between acupuncture and a penetrating sham acupuncture (weighted mean difference = -12.95; 95% CI, -34.05 to 8.15; p=0.23). The latter analysis might have been underpowered. Reviewers noted that previous studies had found that a 24.2-mm change in pain assessed by a 100-mm VAS represents a clinically significant difference and that only 2 of the selected studies had a change of 24.2 mm or more.

Hyaluronic Acid Injection
Systematic Reviews
Several systematic reviews of studies have assessed the use of hyaluronic acid (HA) for treating TMJDs. Three reviews without meta-analysis found benefits to the use of HA. The review by Manfredini et al (2010) included 19 papers that dealt with HA to treat either TMJ disc displacement or inflammatory-degenerative disorders. Eight of the studies were RCTs. All studies reported decreased pain levels, and positive outcomes were maintained over the varying follow-up periods (range, 15 days–24 months). The better outcomes with HA were shown only against placebo saline injections, but outcomes were similar to those seen with corticosteroid
injections or oral appliances. Results of a review of 9 RCTs by Machado et al (2012) showed that intra-articular injections with corticosteroids and HA were effective in controlling TMJD in the short and medium terms. In addition, results indicated that in the short term, intra-articular injections with only HA had similar results to injections with corticosteroids; however, in the long-term, HA was more effective. From the 8 studies included in their systematic review, Goiato et al (2016) found intra-articular injections of HA used in TMJ arthrocentesis are beneficial, but other drugs, such as corticosteroids and non-steroidal anti-inflammatory drug injections are also satisfactory options.

Liu et al. (2017) conducted a systematic review and meta-analysis of RCTs or cohort studies that compared temporomandibular osteoarthritis outcomes in patients treated with intra-articular corticosteroid, hyaluronate, or placebo injection. All 8 selected studies were RCTs; of these, 3 contained data on hyaluronate injection. Compared with placebo, corticosteroid injections prompted a significant decrease in long-term (i.e., ≥6 months post procedure) pain (3 studies; mean difference, -0.74; 95% CI, -1.34 to -0.13; p=0.02; I²=0%). However, in a pooled analysis of 2 studies (both of which included pretreatment arthrocentesis), long-term maximal mouth opening was increased for placebo more than for corticosteroid injection (mean difference, -2.06; 95% CI, -2.76 to -1.36; p<0.001; I²=28%). Only 2 studies were available for comparing corticosteroid with hyaluronate injections, which precluded strong analysis. Short-term pain and mouth opening measures did not significantly differ between any of the injection groups, nor did the incidence of adverse events. The meta-analysis was limited by the small sample sizes of included trials, as well as by the variety of corticosteroid types used. Reviewers concluded that corticosteroid injection following arthrocentesis may be effective for relief of long-term joint pain but may be less effective for improving mouth opening.

Randomized Controlled Trials
Most published RCTs evaluating HA for treating TMJDs have had small sample sizes, short follow-up times, and/or lacked blinding. Representative RCTs with larger sample sizes and stronger methodology are described next.

In their randomized trial, Gokçe Kuyuk et al. (2019) compared platelet-rich plasma (PRP), HA, and intra-articular corticosteroids (CS) to treat patients with TMJ pain and those diagnosed with TMJ-osteoarthritis. Patients were evaluated in 2 groups: those who felt pain on lateral palpation (n=31) and those who felt pain on posterior palpation (n=43). The patients were then randomized to receive either PRP, HA, or CS. TMJ pain (using a 5-point VAS), the presence of crepitation, loss of function, and loss of strength were assessed before treatment and monthly for 3 months following treatment. For patients who had lateral TMJ pain, statistically significant VAS score changes were seen in the PRP and HA groups (p<0.0028 for both groups). In terms of crepitation, function, and strength, some changes were observed in the PRP, HA, and CS groups, but they were not statistically significant (p>0.0028). For patients with posterior TMJ pain, the VAS scores showed significant improvements for PRP, HA, and CS (p<0.0028 for all groups). Some improvements were found in crepitation, function, and strength, but they were not significant. Overall, all 3 treatments significantly improved palpation pain, but the greatest improvement was with PRP.

Gomela et al. (2017) reported on the efficacy of injecting sodium hyaluronate in patients with TMJDs. The trial comprised 62 individuals with the disorder; some members (n=31) of the trial were treated with arthrocentesis, and some members (n=31) were treated by a combination of arthrocentesis and an injection of sodium hyaluronate. Follow-up was observed at 1 week, 2 weeks, 1 month, 3 months, and at 6 months. Using a VAS, patients were asked to measure pain from 1 to 10. Pain decreased significantly for patients in both treatment groups (p<0.001) at the 1 week and the 6-month follow-up; however, patients who were injected with sodium hyaluronate reported a significantly stronger decrease in pain at the 6-month follow-up (p<0.001). Preoperative mean VAS pain scores for patients who received injection started at 6.0; by the 6-month follow-up, the mean VAS pain score was 0.23. Preoperative mean pain scores for patients who received arthrocentesis alone started at 6.77;
by the 6-month follow-up, the mean pain score was 1.71. While not an overwhelmingly significant difference, the trialists concluded that adding an injection of sodium hyaluronate to arthrocentesis treatment can significantly decrease the pain felt by patients who suffer from TMJD.

A study by Manfredini et al. (2012) in Italy randomized 72 patients with TMJD to 1 of 6 treatment groups: (1) single-session arthrocentesis alone; (2) single-session arthrocentesis plus corticosteroid; (3) single-session arthrocentesis plus low-molecular-weight HA; (4) single-session arthrocentesis plus high-molecular-weight HA; (5) 5 weekly arthrocenteses plus low-molecular-weight HA; or (6) 5 weekly single-needle arthrocenteses plus low-molecular-weight HA. Twenty-five (83%) of 72 participants completed the study, with between 9 and 12 patients per treatment group. In a per-protocol analysis, there were no significant differences among groups on any of the outcome variables at the 3-month follow-up. For example, the percentage change in pain at rest ranged from -29.1% in the group receiving 5 weekly single-needle arthrocentesis plus low-molecular-weight HA injections to -38.4% in the group receiving a single-session of arthrocentesis alone. Trial limitations included the small number of patients in each treatment group and the substantial number of dropouts in the absence of an intention-to-treat analysis.

A study by Bjornland et al. (2007) in Norway evaluated 40 patients with osteoarthritis of the TMJ in a double-blind RCT. Patients received 2 injections, 14 days apart, of sodium hyaluronate or corticosteroids. The pain was assessed using a VAS ranging from 0 to 100. Patients were followed for 6 months (assessed at 14 days, 1 month, and 6 months). There was a statistically significant reduction in pain within each group at all follow-up points. At the 6-month follow-up, pain intensity (mean VAS score) was 14 in the HA group and 31 in the corticosteroid group; the between-group difference was statistically significant (p<0.001). The number of patients who were pain-free at 6 months was 7 (35%) of 20 in the HA group and 6 (30%) of 20 in the corticosteroid group (p-value not reported).

Bertolami et al. (1993) published a double-blind placebo-controlled trial that evaluated 121 patients with TMJD. Patients had to have a confirmed diagnosis of degenerative joint disease, reducing displaced disc or nonreducing displaced disc (DDN), failure of other nonsurgical treatments, and severe dysfunction. Patients received a single injection of sodium hyaluronate or saline and were followed for 6 months. Eighty patients were randomized to the hyaluronate group and 41 to the placebo group. This included 57 patients in the degenerative joint disease group, 50 patients in the reducing displaced disc group, and 14 patients in the DDN group. Fourteen (12%) of 121 patients were excluded from the analysis because they did not meet eligibility criteria. Seven outcomes were assessed, including 3 measures of dysfunction, 2 measures of patient perception of improvement, and 2 measures of change in noise. No significant differences in outcomes were seen for the degenerative joint disease group. In the DDN group, there were significant between-group differences through 1 month, favoring the HA group. The number of patients in the DDN group who completed follow-up after 1 month was insufficient to draw meaningful conclusions about efficacy. The most consistent between-group differences in the reducing displaced disc group were for the 2 measures of patient perception of improvement and 1 of the noise variables. There were fewer between-group differences in dysfunction measures.

**Section Summary: Nonsurgical Therapies**

The evidence on acupuncture is limited by the small number of studies, small sample sizes, and in most studies, efficacy assessment only immediately posttreatment. The evidence on the use of HA to treat TMJD is inconclusive, given the methodologic issues with the systematic reviews and RCTs conducted (e.g., small sample sizes) and better surgical options. No reliable evidence is available for biofeedback, TENS, or orthodontic services for TMJD. Overall, the evidence is insufficient to determine that the technologies result in a meaningful improvement in the net health outcome.
Surgical Techniques
Clinical Context and Therapy Purpose
The purpose of surgical techniques in patients with a confirmed diagnosis of TMJD is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as nonsurgical intervention.

The question addressed in this evidence review is: Do surgical therapies improve the net health outcome for individuals with a confirmed diagnosis of TMJD?

The following PICO was used to select literature to inform this review.

Patients
The relevant population of interest is individuals with confirmed TMJD.

Interventions
The surgical therapies being considered are arthrocentesis and arthroscopy.

Patients with confirmed TMJD are actively managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting. Arthrocentesis and arthroscopy are performed by a surgeon at an outpatient facility.

Comparators
The main comparators of interest are alternative nonsurgical intervention, such as intraoral devices and appliances, pharmacologic treatment, acupuncture, biofeedback, TENS, orthodontic services, and HA.

Patients with confirmed TMJD are actively managed by primary care providers, dentists, and otolaryngologists in an outpatient clinical setting.

Outcomes
The general outcomes of interest are symptoms, functional outcomes, quality of life, and treatment-related morbidity. above.

The existing literature evaluating surgical techniques as a treatment for confirmed TMJD has varying lengths of follow-up of up to 6 months. While the systematic reviews described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, at least 6 months of follow-up is considered necessary to demonstrate efficacy.

Study Selection Criteria
Methodologically credible studies were selected using the principles described in the second indication.

In a systematic review, Vos et al. (2013) identified 3 RCTs (total n=222 patients) that compared the efficacy of lavage of the temporomandibular joint (i.e., arthrocentesis or arthroscopy) with nonsurgical temporomandibular joint treatment.28 Although reviewers assessed the quality of the studies to be adequate, only 1 stated that allocation to treatment group was concealed; 2 did not explicitly state use of an intention-to-treat analysis. The 2 primary outcomes considered were change in pain and maximal mouth opening at 6 months compared with baseline. The pain was measured by VAS. Pooled analysis of data from the 3 trials found a statistically significant reduction in pain at 6 months with surgery plus lavage versus nonsurgical therapy (standardized mean difference = -1.07; 95% CI, -1.38 to -0.76). There was no statistically significant difference in the efficacy between the 2 treatments for the other outcome variable, maximal mouth opening (standardized mean difference = 0.05; 95% CI, -0.33 to 0.23).
Observational Studies
In a retrospective cohort study, Hossameldin and McCain (2018) assessed the efficacy of an office-based TMJ arthroscopic technique. The researchers assessed the following outcomes of the procedure: improvement in painless range-of-motion in the mandible, reduced pain on loading, and improvement in functional jaw pain. The cohort included an initial 363 patients, excluded 41, and an analysis was performed on the joints of the remaining 322 that were compromised. Within the 322 patients, 452 joints were operated on with a 66.6% (n=301 joints) success rate (p=.001). It is stated within the outcome variable section that the primary outcome variable of success or failure was determined by the reduction of joint pain postoperatively. This could be subjective. When the operation failed (n=151 joints, 33.3%), 141 joints were involved in a subsequent procedure that ranged from more advanced arthroscopy to a total joint replacement.29

Section Summary: Surgical Techniques
Observational studies and a systematic review of 3 RCTs have shown that the use of arthrocentesis and arthroscopy reduces pain levels in patients with TMJD.

Summary of Evidence
For individuals who have suspected TMJD who receive ultrasound, surface electromyography, or joint vibration analysis, the evidence includes systematic reviews of diagnostic test studies. Relevant outcomes are test validity and other performance measures. None of the systematic reviews found that these diagnostic techniques accurately identified patients with TMJD, and many of the studies had methodologic limitations. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a confirmed diagnosis of TMJD who receive intraoral devices or appliances or pharmacologic treatment, the evidence includes randomized controlled trials (RCTs) and systematic reviews of the RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. A systematic review of intraoral appliances (44 studies) and meta-analyses of subsets of these studies found a significant benefit of intraoral appliances compared with control interventions. Other systematic reviews have found a significant benefit of several pharmacologic treatments (e.g., analgesics, muscle relaxants, and anti-inflammatory medications vs. placebo). One RCT found little benefit and higher adverse events for methylprednisolone versus saline injection. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a confirmed diagnosis of TMJD who receive acupuncture, biofeedback, transcutaneous electrical nerve stimulation, orthodontic services, or hyaluronic acid, the evidence includes RCTs, systematic reviews of these RCTs, and observational studies. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The systematic reviews did not find that these technologies reduced pain or improved functional outcomes significantly more than control treatments. Moreover, many individual studies were small and/or had methodologic limitations. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a confirmed diagnosis of TMJD who receive arthrocentesis or arthroscopy, the evidence includes RCTs, systematic reviews of the RCTs, and observational studies. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Only1 review, which included 3 RCTs, compared arthrocentesis or arthroscopy with nonsurgical interventions for TMJD. Pooled analyses of the RCTs found that arthrocentesis and arthroscopy resulted in superior pain reduction compared with control interventions. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
**Supplemental Information**

**Practice Guidelines and Position Statements**

**American Association for Dental Research**

In 2010 (reaffirmed in 2015), the American Association for Dental Research policy statement recommended the following for the diagnosis and treatment of temporomandibular joint disorders (TMJDs):

“It is recommended that the differential diagnosis of TMDs [temporomandibular disorders] or related orofacial pain conditions should be based primarily on information obtained from the patient’s history, clinical examination, and when indicated, TMJ [temporomandibular joint] radiology or other imaging procedures. The choice of adjunctive diagnostic procedures should be based upon published, peer-reviewed data showing diagnostic efficacy and safety. However, the consensus of recent scientific literature about currently available technological diagnostic devices for TMDs is that except for various imaging modalities, none of them shows the sensitivity and specificity required to separate normal subjects from TMD patients or to distinguish among TMD subgroups....”

“It is strongly recommended that, unless there are specific and justifiable indications to the contrary, treatment of TMD patients initially should be based on the use of conservative, reversible and evidence-based therapeutic modalities. Studies of the natural history of many TMDs suggest that they tend to improve or resolve over time. While no specific therapies have been proven to be uniformly effective, many of the conservative modalities have proven to be at least as effective in providing symptomatic relief as most forms of invasive treatment....”

**American Society of Temporomandibular Joint Surgeons**

In 2001, the American Society of Temporomandibular Joint Surgeons issued consensus clinical guidelines focused on TMJDs associated with internal derangement and osteoarthritis. For diagnosis of this type of TMJD, a detailed history and, when indicated, a general physical examination was recommended. Imaging of the temporomandibular and associated structures was also recommended. Options for basic radiography to provide information on temporal bone and condylar morphology included the use of plain films, panoramic films, and tomograms. Also recommended was imaging of the disc and associated soft tissue with magnetic resonance imaging or arthrography. Other diagnostic procedures indicated included computed tomography, magnetic resonance imaging (MRI), arthrography (for selected cases) and isotope bone scans.

Nonsurgical treatment was recommended as first-line therapy for all symptomatic patients with this condition. Recommended treatment options included a change in diet, nonsteroidal anti-inflammatory drugs, maxillomandibular appliances, physical therapy, injections of corticosteroids or botulinum toxin, and behavior modification. If adequate symptom relief did not occur within 2 to 3 weeks, surgical consultation was advised. The guideline stated the following surgical procedures were considered accepted and effective for patients with TMJDs associated with internal derangement or osteoarthritis:

- Arthrocentesis
- Arthroscopy
- Condylotomy
- Arthrotomy (prosthetic joint replacement may be indicated in selected patients who have severe joint degeneration, destruction, or ankylosis)
- Coronoidotomy/coronoidectomy
- Styloidectomy.

**U.S. Preventive Services Task Force Recommendations**

Not applicable.
Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage
determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 5.

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<th>NCT No.</th>
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<td>Thermograph Evaluation of Masticatory Muscles Pre and Post Indirect Physiotherapeutic Treatment in TMD Subjects: A Randomized, Placebo-controlled Study</td>
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</table>

NCT: national clinical trial.
aDenotes industry-sponsored or cosponsored trial.

References


### Documentation for Clinical Review

**Please provide the following documentation:**
- History and physical and/or consultation notes including:
  - Symptoms
  - Prior medical and surgical treatment and responses
- Diagnostic imaging reports

**Post Service (in addition to the above, please include the following):**
- Operative report(s) (if applicable)
Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

MN/IE
The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

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<td>Arthroscopy: discectomy</td>
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<tr>
<td></td>
<td>D7877</td>
<td>Arthroscopy: debridement</td>
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<td></td>
<td>D7880</td>
<td>Occlusal orthotic device, by report</td>
</tr>
<tr>
<td></td>
<td>D7899</td>
<td>Unspecified TMD therapy by report</td>
</tr>
<tr>
<td></td>
<td>D9950</td>
<td>Occlusion analysis - mounted case</td>
</tr>
<tr>
<td></td>
<td>D9951</td>
<td>Occlusal adjustment - limited</td>
</tr>
<tr>
<td></td>
<td>D9952</td>
<td>Occlusal adjustment - complete</td>
</tr>
<tr>
<td></td>
<td>E1700</td>
<td>Jaw motion rehabilitation system</td>
</tr>
<tr>
<td></td>
<td>E1701</td>
<td>Replacement cushions for jaw motion rehabilitation system, package of 6</td>
</tr>
<tr>
<td></td>
<td>E1702</td>
<td>Replacement measuring scales for jaw motion rehabilitation system, package of 200</td>
</tr>
<tr>
<td></td>
<td>J 7321</td>
<td>Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose (Code revision effective 7/1/2020)</td>
</tr>
<tr>
<td></td>
<td>J 7322</td>
<td>Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg</td>
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</tbody>
</table>
### Type  
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J7323</td>
<td>Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose</td>
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<tr>
<td>J7324</td>
<td>Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose</td>
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<tr>
<td>J7325</td>
<td>Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg</td>
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<tr>
<td>J7326</td>
<td>Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose</td>
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<tr>
<td>J7327</td>
<td>Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose</td>
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<tr>
<td>J7328</td>
<td>Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg</td>
</tr>
<tr>
<td>S8948</td>
<td>Application of a modality (requiring constant provider attendance) to one or more area(s); low-level laser; each 15 minutes</td>
</tr>
</tbody>
</table>

### Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance
with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions' exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.