

Treatment of Temporomandibular Joint (TMJ) Disorders

Policy Number: BIP184.K
Effective Date: May 1, 2023

[➔ Instructions for Use](#)

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Related Benefit Interpretation Policy

- [Dental Care and Oral Surgery](#)

Related Medical Management Guideline

- [Temporomandibular Joint Disorders](#)

Federal/State Mandated Regulations

Texas

<https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1360&Phrases=1360.004&HighlightType=1&ExactPhrase=False&QueryText=1360.004>

TIC Sec. 1360.004. Coverage Required

- A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary as a result of:
 - An accident;
 - A trauma;
 - A congenital defect;
 - A developmental defect; or
 - A pathology.
- Coverage required under this section may be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

TIC Sec. 1360.005. Dental Services Coverage Not Required

- This chapter does not require a health benefit plan to provide coverage for dental services if dental services are not otherwise scheduled or provided as part of the coverage provided under the plan.
- A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or by the dentist providing the dental care. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Washington

RCW 48.46.530 Temporomandibular Joint Disorders-Insurance Coverage

<https://app.leg.wa.gov/rcw/default.aspx?cite=48.46.530>

- Except as provided in this section, a health maintenance agreement entered into or renewed after December 31, 1989, shall offer optional coverage for the treatment of temporomandibular joint disorders.

- a) Health maintenance organizations offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. No health maintenance organizations offering medical and dental coverage may limit benefits in such coverage to dental services related to treatment of temporomandibular joint disorders. No health maintenance organization offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature.
 - b) Health maintenance organizations offering optional temporomandibular joint disorder coverage as provided in this section may, but are not required to, offer lesser or no temporomandibular joint disorder coverage as part of their basic group disability contract.
 - c) Benefits and coverage offered under this section may be subject to negotiation to promote broad flexibility in potential benefit coverage. This flexibility shall apply to services to be reimbursed, determination of treatments to be considered medically necessary, systems through which services are to be provided, including referral systems and use of other providers, and related issues.
2. Unless otherwise directed by law, the insurance commissioner shall adopt rules, to be implemented on January 1, 1993, establishing minimum benefits, terms, definitions, conditions, limitations, and provisions for the use of reasonable deductibles and copayments.
 3. A health maintenance organization need not make the offer of coverage required by this section to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefit statutes under Title 48 RCW that does not provide coverage for temporomandibular joint disorders.

WAC 284-46-506: Temporomandibular joint disorders - Specified Offer of Coverage Required - Terms of Specified Offer Defined - Proof of Offer must be Maintained - Discrimination Prohibited - Terms Defined

<https://apps.leg.wa.gov/wac/default.aspx?cite=284-46-506>

1. Pursuant to RCW [48.46.530](#), each offer of new or renewal group and individual coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporomandibular joint disorders. Health maintenance organizations are encouraged to exercise broad flexibility in designing benefits for these optional temporomandibular joint disorder coverage offerings. However, compliance with the statute shall be demonstrated only when one of the optional temporomandibular joint disorder coverage offerings provides benefits as follows:
 - a) Offers limited to only medical coverage shall provide coverage for medical services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical services shall be the same as are generally provided in the health maintenance agreement for other injuries or musculoskeletal disorders. The coverage provisions may require:
 - (i) That services either be rendered or referred by the covered individual's primary care physician; and
 - (ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and
 - (iii) Pre-notification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or pre-notification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.
 - b) Offers of both medical and dental coverage shall provide coverage for medical and dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical and dental services shall be the same as are generally provided in the health maintenance agreement for other injuries, musculoskeletal disorders, or dental conditions. The coverage provisions may require:
 - (i) That services either be rendered or referred by the covered individual's primary care physician or dentist; and
 - (ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and
 - (iii) Pre-notification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or pre-notification or preauthorization for treatment commencing within forty-eight hours or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint. This subsection applies only in those cases where the offeree has accepted any coverage

2. Offers of the optional coverage required by subsection (1) of this section shall be included on the health maintenance organization's application form(s) and retained by the health maintenance organization for five years or until the completion of the next examination of the health maintenance organization by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the health maintenance organization shall retain other written evidence of the offer of this optional coverage for temporomandibular joint disorders for the same period of time as required for application forms. This subsection applies only in those cases where the offeree has accepted any coverage.
3. With respect to coverage of disorders of the temporomandibular joint, health maintenance organizations shall not engage in discriminatory practices against persons submitting claims for that coverage, nor shall they engage in discriminatory practices against licensed health care providers providing services within the scope of their licensure, for the treatment of disorders of the temporomandibular joint. This shall not prejudice the ability of the health maintenance organization to limit its coverage to its participating providers.
4. For the purposes of the optional coverage for disorders of the temporomandibular joint required by subsections (1) through (3) of this section, the following definitions shall apply and shall be contained in the coverage contract:
 - a) "Temporomandibular joint disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.
 - b) "Medical services" are those which are:
 - (i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
 - (ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
 - (iii) Recognized as effective, according to the professional standards of good medical practice; and
 - (iv) Not experimental or primarily for cosmetic purposes.
 - c) "Dental services" are those which are:
 - (i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
 - (ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
 - (iii) Recognized as effective, according to the professional standards of good dental practice; and
 - (iv) Not experimental or primarily for cosmetic purposes.
5. The requirements listed in the preceding subparagraphs of this section do not apply to those health maintenance agreements exempted by RCW [48.46.066](#) or [48.46.530](#)(3), or other applicable law.

State Market Plan Enhancements

Oklahoma

Coverage for TMJ is limited to Employer Groups with 51+ employees. Coverage for TMJ is not available for Employer Groups with 50 or fewer employees.

Oregon

TMJ coverage is available when selected by the Group.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: For member specific coverage and limitations for the Treatment of TMJ, refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) or contact the Customer Service Department.

Washington

Medically necessary Treatment for Temporomandibular Joint (TMJ) Disorders that result in severe functional impairment and limited jaw movement caused by a medical condition. Severe functional impairment means the impairment is a demonstrable physiologic condition that adversely affects the normal functions of the Temporomandibular Joint and lower and upper jaw.

Texas

Medically necessary Treatment for Temporomandibular Joint (TMJ) Disorders.

Refer to the Medical Management Guideline titled [Temporomandibular Joint Disorders](#).

Not Covered

Refer to the Medical Management Guideline titled [Temporomandibular Joint Disorders](#).

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
05/01/2023	All	<ul style="list-style-type: none">Routine review; no change to benefit coverage guidelinesArchived previous policy version BIP184.J

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.