

# Dental Services, Oral Surgery, and Treatment of Temporomandibular Joint (TMJ)

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[Instructions for Use](#)

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Related Policies
None

## Coverage Guidelines

Dental and oral surgery service are covered when Medicare coverage criteria are met.

**Note:** The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the [Medicare Coverage Database](#) to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations, and Local Coverage Articles).

### Dental Services or Oral Surgery

Dental services or oral surgery, rendered by a physician or dental professional, for treatment of primary medical conditions are covered. The dental procedures are not covered. Examples of these non-covered services are items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

- **Outpatient (Part B) Services including Ambulatory Surgery Center Procedures**  
 Whether services such as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered. For coverage of inpatient (Part A) facilities and anesthesia charges, refer to the [coverage guidelines](#) below.
- **Place of Service**  
 Medicare makes payment for a covered dental procedure no matter where the service is performed. The hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.
- **Services Performed by a Dentist**
  - If an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by the dentist, the total service performed by the dentist on such an occasion is covered.
  - Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth.

- A dentist qualifies as a physician if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathic medicine and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections, and interpretations of diagnostic X-ray examinations in connection with covered services. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services](#).

Also refer to the following:

- [Medicare Benefit Policy Manual, Chapter 16, §140 – Dental Services Exclusion](#)
- [Medicare Benefit Policy Manual, Chapter 15, §260.5 – List of Covered Ambulatory Surgical Center Procedures](#)
- [Medicare General Information, Eligibility, and Entitlement, Chapter 5, §70.2 – Dentists](#)
- [Medicare Benefit Policy Manual, Chapter 1, §70-70 – Inpatient Services in Connection With Dental Services](#)

(Accessed July 5, 2023)

## ***Examples of Covered Services***

### **Setting of the Jaw or Facial Bones**

Setting of the jaw or facial bones (includes wiring of the teeth when performed in connection with the reduction of a jaw fracture).

- Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints.
- Dental splints used to treat a dental condition are excluded from coverage under 1862(a)(12) of the Act. On the other hand, if the treatment is determined to be a covered medical condition (i.e., dislocated upper/lower jaw joints), then the splint can be covered.

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services](#). (Accessed July 5, 2023)

### **Reconstruction of a Ridge**

Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes). Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services](#). (Accessed July 5, 2023)

### **Extraction of Teeth to Prepare the Jaw for Radiation Treatments of Neoplastic Disease**

Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is covered. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services](#). Also refer to the [Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion](#). (Accessed July 5, 2023)

### **Inpatient Hospital Services and Dental Services**

Payment may be made under part A in the case of inpatient hospital services in connection with the provision of dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services. Refer to the Statutory Dental Exclusion section of the Medicare Dental Coverage Overview at <http://www.cms.hhs.gov/MedicareDentalCoverage/> and the [Medicare Benefit Policy Manual, Chapter 1, §70 – Inpatient Services in Connection With Dental Services](#). (Accessed July 5, 2023)

### **Oral or Dental Examinations Prior to Kidney Transplantation or Heart Valve Replacement**

Oral or dental examinations, but not treatment, performed inpatient as part of a comprehensive workup prior to kidney/renal transplantation surgery or heart valve replacement. Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital's staff, or under Part B if performed by a physician. Refer to the [NCD for Dental Examination Prior to Kidney Transplantation \(260.6\)](#). Also refer to the [Medicare Dental Coverage Overview](#).

(Accessed July 5, 2023)

## **Inpatient (Part A) Facilities and Anesthesia Charges**

Facilities and anesthesia charges in an inpatient facility, when a dental procedure cannot be performed in a dental office due to an underlying medical condition and clinical status or the severity of a non-covered dental procedure, are covered. (For anesthesia coverage for Part B services, refer to the notation for [Outpatient \(Part B\) Services including Ambulatory Surgery Center Procedures](#) above.)

Facilities and anesthesia charges in an inpatient facility, when a dental procedure cannot be performed in a dental office due to an underlying medical condition and clinical status or the severity of a non-covered dental procedure, are covered.

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital.

When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with the non-covered dental procedures are not covered. Examples of these non-covered services are items and services of an anesthesiologist, radiologist, or pathologist in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

Refer to the [Medicare Benefit Policy Manual, Chapter 1, §70 – Inpatient Services in Connection With Dental Services Covered Under Part A](#) and the [Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services](#).

The attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status or the severity of the dental procedure requires the patient to be admitted to the hospital for the performance of the dental procedure, and to recertify the patient's continuing need for hospitalization when required. This applies even if the dental procedure is not covered. Refer to the [Medicare General Information, Eligibility, and Entitlement, Chapter 4, §10.3 – Certification for Hospital Admissions for Dental Services](#). (Accessed July 5, 2023)

## **Dentures**

Denture as part of the prosthesis when the denture or a portion of denture is an integral part (built-in) of a covered prosthesis (e.g., an obturator which fills an opening in the palate). Refer to the [Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices, C – Dentures](#). (Accessed July 5, 2023)

## **Temporomandibular Joint (TMJ)**

There are a wide variety of conditions that can be characterized as TMJ, and an equally wide variety of methods for treating these conditions. Many of the procedures fall within the Medicare program's statutory exclusion that prohibits payment for items and services that have not been demonstrated to be reasonable and necessary for the diagnosis and treatment of illness or injury (§1862(a)(1) of the Act). Other services and appliances used to treat TMJ fall within the Medicare program's statutory exclusion at 1862(a)(12), which prohibits payment "for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth..." For these reasons, a diagnosis of TMJ on a claim is insufficient. The actual condition or symptom must be determined. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150.1 – Treatment of Temporomandibular Joint Syndrome](#). (Accessed July 5, 2023)

## **Examples of TMJ Treatment**

### **Oral Medications**

May be available for coverage under the member's Part D plan benefit; contact the Prescription Solutions customer service department to determine coverage eligibility for UnitedHealthcare Part D prescription drug plan benefit.

### **Botulinum Toxins A and B**

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Botulinum Toxin Types A and B](#).

**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled [Botulinum Toxins A and B](#).

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed August 20, 2023)

## TMJ Devices and Supplies

For jaw motion rehabilitation system (HCPCS codes E1700 - E1702), refer to the Coverage Summary titled [Durable Medical Equipment \(DME\), Prosthetics, Orthotics \(Non-Foot Orthotics\), Nutritional Therapy, and Medical Supplies Grid](#) (Jaw Motion Rehabilitation System).

For traction equipment (E0849 or E0855) for the treatment of TMJ, refer to the Coverage Summary titled [Durable Medical Equipment \(DME\), Prosthetics, Orthotics \(Non-Foot Orthotics\), Nutritional Therapy, and Medical Supplies Grid](#) (Traction Equipment).

## Arthrocentesis

Medicare does not have a National Coverage Determination for arthrocentesis for treatment of TMJ. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy for [Treatment of Temporomandibular Joint Disorders](#).

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed August 20, 2023)

## Treatments Such as the Injection of Corticosteroid, Physical Therapy, Arthroscopy, or Arthroplasty

Medicare does not have a National Coverage Determination (NCD) for corticosteroid injections, physical therapy, arthroscopy, or arthroplasty used in treatment of TMJ. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy for [Treatment of Temporomandibular Joint Disorders](#).

The following services are unproven and not medically necessary for treating disorders of the temporomandibular joint (TMJ) due to insufficient evidence of efficacy (this list is not all-inclusive):

- Biofeedback
- Craniosacral manipulation/therapy
- Passive rehabilitation therapy
- Low-load prolonged-duration stretch (LLPS) devices
- Multiple occlusal splints (i.e., daytime and nighttime splints, maxillary and mandibular splints)

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed August 20, 2023)

## Sodium Hyaluronate Injections

Medicare does not have a National Coverage Determination (NCD) for sodium hyaluronate injections used in treatment of TMJ. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled [Sodium Hyaluronate](#).

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed August 20, 2023)

## Orthognathic Surgery (CPT Codes 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21210, 21215, 21244, 21245, 21246, and 21247)

Medicare does not have a National Coverage Determination (NCD) for orthognathic surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where

applicable. These LCDs/LCAs are available at <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>.

**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled [Orthognathic \(Jaw\) Surgery](#).

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed January 12, 2024)

## Examples of Dental Services and Oral Surgery Services That are Not Covered

- Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. “Structures directly supporting the teeth” means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services](#) and the [Medicare Benefit Policy Manual, Chapter 16, §140 – Dental Services Exclusion](#).
- Cosmetic surgery or treatment provided solely to improve the member’s appearance and not intended to improve the physical functioning of a malformed body part(s). Refer to the [Medicare Benefit Policy Manual, Chapter 16, § 120 – Cosmetic Surgery](#).
- Application of dental/orthodontic devices/appliances whether or not it accompanies oral and/or orthognathic surgery, except for the treatment of Temporomandibular Joint (TMJ) Disorders. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §150.1 – Treatment of Temporomandibular Joint \(TMJ\) Syndrome](#).
- For coverage guideline for the treatment of TMJ, refer to [Temporomandibular Joint \(TMJ\)](#).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for Dental Services exist. Compliance with these policies is required where applicable. These LCDs/LCAs are available at <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>. (Accessed July 5, 2023)

## Definitions

**Cosmetic Surgery:** Cosmetic or reconstructive surgery used to alter and improve the member's physical appearance or to improve the member's self-esteem and which provides no improvement to a functional impairment. [Medicare Benefit Policy Manual, Chapter 16, § 120 – Cosmetic Surgery](#). (Accessed July 5, 2023)

**Dental Prosthesis:** An artificial device that replaces one or more missing teeth. American Dental Association Glossary at [Glossary of Dental Clinical Terms, American Dental Association \(ada.org\)](#). (Accessed July 5, 2023)

## Supporting Information

Botulinum Toxin Types A and B				
Accessed September 13, 2023				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L35172 (A57186)	<a href="#">Botulinum Toxin Types A and B</a>	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L35170 (A57185)	<a href="#">Botulinum Toxin Types A and B Policy</a>	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA, GU, HI, MP, NV

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## Policy History/Revision Information

Date	Summary of Changes
09/01/2024	<b>Coverage Guidelines</b> <b>Examples of TMJ Treatment</b> Orthognathic Surgery (CPT Codes 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21210, 21215, 21244, 21245, 21246, and 21247)



Date	Summary of Changes
	<ul style="list-style-type: none"> <li>Updated list of applicable CPT codes; removed 21120, 21121, 21122, 21123, 21125, and 21127</li> </ul> <p><b>Administrative</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version MCS025.06</li> </ul>

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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