

| POLICY NUMBER | EFFECTIVE DATE | APPROVED BY |
|---------------|----------------|--------------------------------|
| M20200047 | 01/01/2020 | MPC (Medical Policy Committee) |

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Related Guidelines

- [Cosmetic Surgery](#)
- [Orthognathic Surgery](#)

Guideline

Medically necessary oral surgical procedures provided by a doctor when pre-authorized are covered in the following circumstances:

1. For the treatment of tumors, cysts, injuries of the facial bones; OR
2. For the treatment of fractures and dislocations involving the face and jaw, including temporomandibular joint (TMJ) dysfunction surgery (for demonstrable joint disease only) or temporomandibular disease (TMD) syndrome.

Limitation/Exclusion

There is no coverage for non-surgical treatment of temporomandibular joint (TMJ) dysfunction (for demonstrable joint disease only) or temporomandibular disease (TMD) syndrome, including but not limited to appliances, behavior modification, physiotherapy and prosthodontic therapy.

Applicable Coding

| Applicable CPT Codes | |
|----------------------|--|
| 21110 | Application of interdental fixation device for conditions other than fracture or dislocation, includes removal |
| 21243 | Arthroplasty, temporomandibular joint, with prosthetic joint replacement |

References

2020 ConnectiCare Insurance Company, Inc. Membership Agreement

Revision history

| DATE | REVISION |
|------------|--|
| 01/01/2020 | <ul style="list-style-type: none">Reformatted and reorganized policy, transferred content to new template with new Medical Policy NumberAnnual Review. Added related guidelines. Removed codes that are not part of the oral surgery category on the 2020 Prior Authorization list. |
| 11/04/2016 | <ul style="list-style-type: none">Annual Review |