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2025 Magnetic Resonance Imaging (MRI) Temporomandibular Joint (TMJ)

Diagnostic Imaging

MRI-TMJ-HH

Last Review Date: 09/09/2025
Previous Review Date: 04/14/2025
Guideline Initiated: 06/30/2019

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Magnetic Resonance Imaging (MRI) Temporomandibular Joint (TMJ)

MRI TMJ Related National Coverage Determination (NCD)/ Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's health plan membership.

Type/ID Number	Title
NCD 220.2	MRI
LCD 37373	MRI and CT Scans of the Head and Neck

Clinical Judgment

These medical policies are designed to provide clinical guidance and do not supplant a provider's independent professional judgment. Physicians retain full and independent authority to determine appropriate care based on each patient's individual clinical circumstances. Although services may be subject to documentation requirements, medical necessity review, or coverage limitations, nothing in this policy is intended to restrict or interfere with a physician's independent medical judgment.

MRI General Contraindications

MRI is contraindicated for **ANY** of the following:

- Safety, related to clinical status (body mass index exceeds MRI capability, intravascular stents within recent 6 weeks)
- Safety, related to implanted devices (aneurysm clips, cochlear implant, implantable cardio-defibrillators, insulin pump, permanent pace maker, spinal cord stimulator)[1]
  References: [11] [5] [9]

Preamble: Pediatric Diagnostic Imaging

HealthHelp's clinical guidelines for the Diagnostic Imaging program, are intended to apply to both adults and pediatrics (21 years of age or younger), unless otherwise specified within the criteria.

[1]Some implanted devices that were once absolute contraindications to a MRI may now be accepted, including if the specific MRI is able to accommodate the device or the device itself is deemed safe for MRI.

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MRI TMJ Guideline

Magnetic resonance imaging (MRI) of the temporomandibular Joint (TMJ) is considered medically appropriate when the documentation demonstrates an evaluation is needed for **ANY** of the following conditions:

1. Juvenile idiopathic arthritis (JIA) evaluation (eg, joint pain, swelling and redness)
   References: [16] [15]
2. Pre-procedural evaluation, to guide treatment planning or post-surgical assessments (within 90 days of procedure) for evaluation of complications or disease recurrence
   References: [2]
3. Prior ultrasound or X-ray is abnormal, non-diagnostic or indeterminate.
4. Temporomandibular joint dysfunction (TMJ) with suspected internal joint derangement when **ALL** of the following conditions are met: (*__NOTE__: *If there was recent dental infection, dislocation, malocclusion or trauma, a X-ray should be the initial study.*)
   a. Conservative management for **at least** 4 weeks with anti-inflammatory medication **AND** behavioral modification (eg, cognitive behavioral therapy, muscle relaxers, occlusal devices, patient education, physical therapy, self-care)
   b. Symptoms are persistent (facial or jaw pain, pain/noise with chewing, restricted range of motion).

   References: [7] [4]

Head and Neck Cancer Surveillance section

Bone Cancer Surveillance

Bone cancer surveillance includes **ANY** of the following:

1. Chondrosarcoma surveillance for **ANY** of the following:
   a. Atypical cartilaginous tumor surveillance with cross-sectional imaging (CT + contrast, MRI ± contrast) every 6 to 12 months for 2 years, then annually as clinically indicated
   b. Low-grade, extracompartmental appendicular tumor, grade I axial tumors or high-grade (grade II or III, clear cell or extracompartmental) tumors surveillance with **ALL** of the following:
      i. Chest CT at least every 6 months for 5 years, then annually for at least 10 years, then if symptoms are new or progressing.
      ii. MRI (± contrast) or CT (+ contrast) if symptoms are new or progressing.

2. Chordoma surveillance with **ALL** of the following:
    a. Chest CT imaging every 6 months, annually for 5 years, then annually thereafter, then if symptoms are new or worsening.
    b. Imaging of primary site, timing and modality (eg, MRI ± CT [both + contrast]) if symptoms are new or progressing, up to 10 years
3. Ewing Sarcoma after primary treatment completed surveillance with **ALL** of the following:
    a. Chest CT: every 3 months
    b. Primary site imaging with MRI ± CT (both + contrast), increase intervals after 24 months and after 5 years, annually, then if symptoms are new or progressing (indefinitely) (*__NOTE__: *PET/CT [head-to-toe] is appropriate*)
4. Giant cell tumor of the bone surveillance with **ALL** of the following:
    a. Chest CT or MRI imaging every 6 to 12 months for 4 years, then annually thereafter, then if symptoms are new or progressing
    b. Surgical site imaging if symptoms are new or progressing (eg, CT and/or MRI, both with contrast)
5. Osteosarcoma surveillance with primary site and chest imaging (using same imaging that was done for initial work-up) for **ANY** of the following: (*__NOTE__: *PET/CT [head-to-toe] is appropriate*.)
    a. Image every 3 months for years 1 and 2
    b. Image every 4 months for year 3
    c. Image every 6 months for years 4 and 5
    d. Image annually for year 6 and thereafter, then if symptoms are new or progressing

References: [2025 Bone Cancer Version 1.2026]

Central Nervous System (CNS) Cancer Surveillance

Central nervous system (CNS) cancer surveillance includes **ANY** of the following:

1. Brain metastasis, limited **OR** extensive, image with brain magnetic resonance imaging (MRI) every 2 to 3 months for 1 to 2 years, then every 4 to 6 months indefinitely
2. Glioblastoma, *IDH* wild-type, magnetic resonance imaging with (MRI) of the brain and **ANY** of the following:
    a. Pre-operative and post-operative; within 48 hours
    b. Pre-radiation planning; every 3 to 5 weeks, post-operatively

c. Post-radiation; 3 to 6 weeks post-radiation, then every 2 to 3 months for 3 years, then every 2 to 4 months indefinitively

3. Glioma, imaging with MRI of the brain and **ANY** of the following:
   a. Astrocytoma, *IDH* mutated and **ANY** of the following:
      i. Grade 2 and **ANY** of the following:
         A. After radiation therapy (RT) **AND** chemotherapy: every 6 months until tumor progression
         B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
         C. After surgery: every 3 to 4 months until tumor progression
      ii. Grade 3 and **ANY** of the following;
         A. After RT **AND** chemotherapy: every 6 months until tumor progression
         B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
      iii. Grade 2 or 3, recurrent; image every 2 to 3 months
   b. Oligodendroglioma, *IDH* mutated, 1p/19q co-deleted and **ANY** of the following:
      i. Grade 2 and **ANY** of the following:
         A. After radiation therapy (RT) **AND** chemotherapy: every 6 to 9 months until tumor progression
         B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
         C. After surgery: every 3 to 4 months until tumor progression (*__NOTE__: *For individuals who underwent gross total resection, every 6 to 9 months for 5 years post-surgery until tumor progression*)
      ii. Grade 3 and **ANY** of the following:
         A. After radiation therapy (RT) **AND** chemotherapy: every 6 to 9 months until tumor progression
         B. After RT **OR** chemotherapy: every 3 to 4 months for the 1st 5 years, then every 3 to 4 months until tumor progression
      iii. Grade 2 or 3, recurrent, image every 3 to 4 months
4. Leptomeningeal metastases imaging with MRI of the brain and/or total spine every 2 to 3 months for the 1st 2 years, every 6 months until year 5, then annually indefinitively

5. Medulloblastoma, imaging with MRI of the brain every 2 to 3 months for 2 years
6. Primary CNS lymphoma, image every 2 to 3 months for 2 years

References: [12]

Esophageal and Esophagogastric Junction Cancer Surveillance

Esophageal and esophagogastric junction cancer surveillance includes **ANY** of the following[2]:

1. Adenocarcinoma, squamous cell carcinoma; imaging studies if symptoms are new or progressing
2. Tumor classification T1b[a] (N0 on ultrasound) after endoscopic resection or ablation, imaging surveillance includes computed tomography (CT) chest and abdomen (+ contrast, unless **contraindicated**) every 6 months for the first 2 years and annually for up to 5 years
3. Tumor classification T1b or greater, any N[a] or T1a N+, imaging surveillance includes esophagectomy performed with or **WITHOUT** adjuvant therapy then surveillance includes chest and abdomen CT (+ contrast, unless **contraindicated**) every 6 months for the first 2 years and annually for up to 5 years
4. Tumor classification any T and/or any N, with neoadjuvant chemotherapy **OR** chemoradiotherapy **AND** esophagectomy, with or **WITHOUT** adjuvant treatment, imaging surveillance includes chest and abdomen CT (+ contrast, unless **contraindicated**) every 6 months for up to 2 years, then annually for up to 5 years and EGD, then if symptoms are new or progressing
5. Tumor classification (pretreatment) N0 to N+, T1b to T4, T4b, with definitive chemoradiation (**WITHOUT** esophagectomy), surveillance imaging includes chest and abdomen CT (+ contrast unless **contraindicated**) every 3 to 6 months for the first 2 years and annually for up to 5 years

References: [1]

Head and Neck Cancers Surveillance

Head and neck cancers surveillance for locoregionally advanced disease after treatment, includes **ANY** of the following:

1. Short-term surveillance (less than 6 months after treatment), if there is high-risk of early recurrence, symptoms of early recurrence or before starting adjuvant post-operative therapy:

[2]Routine esophageal/esophagogastric junction cancers are **NOT** recommended for cancer-specific surveillance, for more than 5 years after the end of treatment.

a. Computed tomography (CT) or magnetic resonance imaging (MRI) within 3 to 4 months post-operatively to establish a new baseline for future comparisons

b. FDG positron emissions tomography/computed tomography (FDG PET/CT) within 3 to 6 months of definitive radiation or systemic therapy/RT.

c. Incomplete response is suspected: CT or MRI scan earlier (eg, 4 to 8 weeks) based on new or progressing symptoms. (*__NOTE__: *Use ultrasound [US] of the neck for targeted sampling.*)

2. Long-term surveillance (6 months or more from end-of-treatment, up to 5 years after treatment) with CT, MRI, FDG PET/CT to obtain surveillance for lesions that are recurrent, second primary or at distant sites.[3]

References: [13]

Histiocytic Neoplasms Surveillance

NCCN Histiocytic Neoplasms Version 3.2024

Histiocytic neoplasms surveillance imaging includes **ANY** of the following:

1. Erdheim-Chester disease surveillance imaging includes **ANY** of the following:

   a. Fluorodoxyglucose (FDG)-positron emission tomography/computed tomography (PET/CT) every 3 to 6 months after starting therapy until stabilization of the disease, and as clinically indicated after 2 years.

   b. Organ specific imaging with CT (+ contrast) or MRI (± contrast) every 3 to 6 months until disease stabilization and then every 6 to 12 months

2. Langerhans cell histiocytosis surveillance imaging includes FDG-PET/CT , FDG-PET or CT/ magnetic resonance imaging (MRI) every 3 to 6 months for the first 2 years after completion of therapy, then **NO** more than annually (*__NOTE__: *For individuals who are asymptomatic with a single-site bone lesion, imaging surveillance can end after 1 year, with continued tracking of symptoms*)

3. Rosai-Dorfman disease (RDD), surveillance imaging includes **ANY** of the following: (*__NOTE__: *for individuals who are asymptomatic with a single-site bone lesion, imaging surveillance can end after 1 year, with continued tracking of symptoms*)

[3]Per the National comprehensive cancer network (NCCN) Guidelines for Head and Neck Cancers, there are no consensus guidelines for the surveillance imaging type, frequency or duration for locoregionally advanced disease. If an FDG PET/CT at 3 months post-treatment is negative, there are no data to support substantial benefit for further routine imaging when asymptomatic with negative exam. In the absence of multi-institutional prospective data, a tailored approach to surveillance with attention to tumor type, stage, prognostic factors, symptomatology and physical exam changes or restrictions is recommended.

a. FDG-PET/CT every 3 to 6 months after starting therapy until stabilization of disease

b. Organ specific imaging with CT (+ contrast) or MRI (± contrast) every 3 to 6 months until disease stabilization and then every 6 to 12 months

References: [8]

Melanoma: Uveal Surveillance

Uveal melanoma surveillance imaging includes **ANY** of the following:

1. Low risk disease surveillance imaging every 12 months for 5 years or clinically as indicated, includes **ANY** of the following:
    a. Chest/abdomen/pelvis computed tomography (CT) (+ contrast)
    b. Magnetic resonance (MR) (+ contrast) or ultrasound of liver
2. Medium risk disease surveillance imaging every 6 to 12 months for 10 years, then as clinically indicated, includes **ANY** of the following:
    a. Chest/abdomen/pelvis CT (+ contrast)
    b. MR (+ contrast) or ultrasound of liver
3. High risk disease surveillance imaging every 3 to 6 months for 5 years, then every 6 to 12 months for 10 years, then clinically as indicated, includes **ANY** of the following:
    a. Chest/abdomen/pelvis CT (+ contrast)
    b. MR (+ contrast) or ultrasound of liver

References: [17]

Pediatric Central Nervous System Cancers

Pediatric central nervous system cancer surveillance includes **ANY** of the following:

1. Medulloblastoma and **ANY** of the following:
    a. Risk is low or average (after completion of adjuvant/maintenance treatment) and **ALL** of the following:
        i. Brain magnetic resonance imaging (MRI) every 3 to 4 months for 2 years, then every 6 months for 3 years, then if symptoms are new or progressing.
        ii. Spine MRI (cervical, lumbar **AND** thoracic) every 6 months for 2 years, then if symptoms are new or progressing.
    b. Risk is high or very high (after completion of adjuvant/maintenance treatment) and **ANY** of the following:

i. Brain MRI every 3 to 4 months for 2 years, then every 6 months for 3 years, then if symptoms are new or progressing.

ii. Spine MRI (cervical, lumbar **AND** thoracic) every 3 to 4 month for 2 years, then annually for 3 years, then if symptoms are new or progressing.

2. Pediatric diffuse high-grade glioma, image with brain MRI 2 to 6 weeks after radiation therapy, then every 2 to 3 months for year 1, then every 3 to 6 months indefinitely

References: [6]

Soft Tissue Sarcoma Surveillance

Soft tissue sarcoma surveillance includes **ANY** of the following: (***NOTE**: *Use contrast imaging; for long term surveillance to minimize radiation exposure,MRI may be substituted.*)

1. Desmoid tumor (aggressive fibromatosis) imaging surveillance includes computed tomography (CT) or magnetic resonance imaging (MRI) every 3 to 6 months for 3 years, then every 6 to 12 months thereafter
2. Extremity, trunk or head and neck, for long-term follow-up with **ANY** of the following:
   a. Long-term follow-up with **ALL** of the following:
      i. Chest CT imaging (- contrast) to detect asymptomatic distant recurrence
      ii. MRI for imaging of primary site
   b. Stage I tumors and **ALL** of the following:
      i. Chest CT imaging (- contrast) every 6 to 12 months
      ii. Post-operative baseline and periodic imaging of primary site with MRI or CT if MRI is **contraindicated or unavailable**.
   c. Stage II and III tumors and **ANY** of the following:
      i. Baseline and periodic imaging of primary site
      ii. Chest and other known sites of metastatic disease imaging (CT [- contrast] or X-ray) every 2 to 6 months for 2 to 3 years, then every 6 months to complete a total of 5 years, then annually.
      iii. Post-operative reimaging to assess the primary tumor site and rule out metastatic disease (MRI or CT if MRI is **contraindicated or unavailable**.
3. Retroperitoneal/intra-abdominal, after management of primary disease imaging surveillance includes chest/abdomen/pelvis CT or MRI every 3 to 6 months for 3 years, then every 6 months for the next 2 years, then annually.

References: [18]

Thymomas and Thymic Carcinomas Surveillance

Thymomas and thymic carcinomas surveillance after primary treatment includes **ANY** of the following:

1. R0 resection surveillance imaging with chest computed tomography (CT) (+ contrast) or magnetic resonance imaging (MRI) for **ANY** of the following:
    a. Thymic carcinoma every 6 to 12 months for 2 years, then annually until year 5
    b. Thymoma every 6 months for 2 years, then annually until year 10
2. R1 and R2 resection surveillance imaging with chest CT (+ contrast) or MRI for **ANY** of the following:
    a. Thymic carcinoma every 3 to 6 months for 2 years, then annually for 5 years
    b. Thymoma every 6 months for 2 years, then annually for 10 years
3. Locally advanced disease surveillance imaging with chest CT (+ contrast) or MRI for **ANY** of the following:
    a. Thymic carcinoma every 3 to 6 months for 2 years, then annually for 5 years
    b. Thymoma every 6 months for 2 years, then annually for 10 years

References: [14]

Thyroid Carcinoma Surveillance

Thyroid carcinoma surveillance imaging includes **ANY** of the following:

1. Anaplastic carcinoma (stage IVC surveillance imaging includes computed tomography (CT) or magnetic resonance imaging (MRI) (+ contrast) of brain, neck, chest, abdomen and pelvis at frequent intervals as clinically indicated (*__NOTE__: *consider fluorodeoxyglucose-positron emission tomography (FDG-PET)/CT 3 to 6 months after initial therapy*)
2. Medullary carcinoma surveillance imaging includes **ANY** of the following:
    a. MRI of whole body, if calcitonin levels are very elevated 150 pg/ml or more.
    b. Calcitonin level is 150 pg/ml or more: surveillance with CT or MRI (+ contrast) of the neck, chest, and liver, as clinically indicated
    c. FDG-PET/CT or Ga-68 DOTATE or MRI (+ contrast) of the neck, chest, abdomen with liver protocol, based on calcitonin/carcinoembryonic antigen (CEA) doubling time

References: [10]

MRI TMJ Procedure Codes

Table 1. MRI Temporomandibular Joint (TMI) Associated Procedure Codes

CODE	DESCRIPTION
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)

MRI TMJ Summary of Changes

MRI TMJ guideline had the following version changes from 2024 to 2025:

Table 1. 2025 TMJ Summary of Changes

Date	Type of Change	Summary
12/01/2025	Mid-Cycle	• Removed LCD 35175 due to retirement
09/09/2025	Mid-Cycle	• Added examples to "Juvenile idiopathic arthritis" • Added time frame for "post-surgical assessment" in "Pre-procedural" indication
04/14/2025	Annual	• Citations updated per the evidence • Removed combination studies as they are redundant • Removed "Prior MRI TMJ imaging" indication as it is no longer supported by evidence and is too broad

MRI TMJ Definitions

Conservative management is an approach to treating pain utilizing non-surgical treatment options such as physical therapy, medication and injections, for a designated time, usually 4 to 6 weeks.

Dislocation is a separation of two bones where they meet at a joint. This injury can be very painful and can temporarily deform and immobilize the joint.

Indeterminate findings are inconclusive or insufficient for treatment planning.

Internal joint derangement refers to a condition where structures within a joint, like ligaments, cartilage or menisci, are damaged or displaced, leading to pain, instability and potentially limited movement.

Juvenile idiopathic arthritis refers to joint swelling (inflammation) and stiffness that affects one or more joints, for at least 6 weeks, in a child age 16 or younger.

Magnetic resonance imaging (MRI) is a non-invasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.

Non-diagnostic is a result that does not lead to a confirmed diagnosis.

Pediatric approximate ages are defined by the US Department of Health (USDH), the Food and Drug Administration (FDA), and the American Academy of Pediatrics (AAP) as the following:

1. Infancy, between birth and 2 years of age
2. Childhood, from 2 to 12 years of age
3. Adolescence, from 12 to 21 years of age, further defined by the AAP into:
    a. Early (ages 11–14 years)
    b. Middle (ages 15–17 years),
    c. Late (ages 18–21 years)
    d. Older ages may be appropriate for children with special healthcare needs.

Temporomandibular Joint (TMJ) is the diarthrosis between the temporal bone and mandible that includes the condyloid process below separated by an articular disk from the glenoid fossa above and that allows for the opening, closing, protrusion, retraction and lateral movement of the mandible.

Temporomandibular Joint (TMJ) dysfunction is a group of more than 30 conditions that cause pain and dysfunction in the jaw joint and muscles that control jaw movement.

Ultrasound is the diagnostic or therapeutic use of ultrasound and especially a noninvasive technique involving the formation of images used for the examination and measurement of internal body structures and the detection of bodily abnormalities.

MRI TMJ References

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.
CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.
In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

11248 11249 11253 11282 11325 11328 11333 11349 11350 11351 11352 11354 11355 11356 11358 11359 11360 11361 11362 11365 11366 11367 11368 11369 11370 11374 11375 11394 11395 11396 11565