Facial Prostheses

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification, as applicable.

Facial prostheses require precertification.

National Coverage Determination Policy	**None**
Local Coverage determination Policy	**Jurisdiction B-C**
Effective Date	**For services on or after: 05/01/14**
Revision/ Review Date	**01/19, 10/18, 06/04/2018, 04/01/17, 01/01/2016**
The Health Plan	**Plans will follow Coverage Determination posted on the CGS website unless otherwise indicated in sections of this policy, contractual agreements, or benefit plan documents.**

DESCRIPTION

A facial prosthetic or facial prosthesis is an artificial device used to change or adapt the outward appearance of a person's face or head.

COVERAGE GUIDELINES

A facial prosthesis is covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect.

A separate physician order is not required for subsequent modifications, repairs, or replacement of a facial prosthesis. A new order is required when different supplies are ordered.

When code V2629 or L8048 is billed, the referral/claim must be accompanied by a brief description of the item in the narrative field. When L8048 is provided, a drawing/photograph of the item must be available upon request.

Adhesives, adhesive remover, skin barrier wipes, and tape used in conjunction with a facial prosthesis are covered.

Please refer to the West Virginia Medicaid website for proper coding of oral, facial prosthesis.

NONCOVERAGE STATEMENT

Skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are noncovered.

Palatal Lift Prostheses are coded with dental codes- **D5955**: definitive, **D5958**: interim, **D5959**: modification, and are subject to benefit review.

REPAIR, REPLACEMENT AND REASONABLE USEFUL LIFETIME

Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for replacement prosthesis, no payments can be made for the amount of the excess.

Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis, are noncovered services. They are included in the global fee for the initial service.

Replacement of a facial prosthesis is covered in cases of loss or irreparable damage, wear, or when required because of a change in the patient's condition that cannot be accommodated by modification of the existing prosthesis. When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be clearly documented in the supplier's records and be available upon request.

When a replacement prosthesis is fabricated starting with a new impression/moulage, the KM modifier should be added to the code. When a replacement prosthesis is fabricated using a previous master model, the KN modifier should be added to the code.

Covered modifications or repairs are billed using code L8049 for the labor components and code L8048 for any materials used. Time reported using code L8049 should only be for laboratory modification/repair time and associated prosthetic evaluation used only for services after 90 days from the date of delivery of the prosthesis. Evaluation not associated with repair or modification is non-covered and should not be coded as L8049.

CODING INFORMATION

HCPCS MODIFIERS

AV	ITEM FURNISHED IN CONJUNCTION WITH A PROSTHETIC DEVICE, PROSTHETIC OR ORTHOTIC
EY	NO PHYSICIAN OR OTHER HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE

KM	REPLACEMENT OF FACIAL PROSTHESIS INCLUDING NEW IMPRESSION/MOULAGE
KN	REPLACEMENT OF FACIAL PROSTHESIS USING PREVIOUS MASTER MODEL
LT	LEFT SIDE
RT	RIGHT SIDE

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

A4364	ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PER OZ
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE
A4456	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE
A5120	SKIN BARRIER, WIPES OR SWABS, EACH
L8040	NASAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8041	MIDFACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8042	ORBITAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8043	UPPER FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8044	HEMI-FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8045	AURICULAR PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8046	PARTIAL FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8047	NASAL SEPTAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN
L8048	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT, PROVIDED BY A NON-PHYSICIAN
L8049	REPAIR OR MODIFICATION OF MAXILLOFACIAL PROSTHESIS, LABOR COMPONENT, 15 MINUTE INCREMENTS, PROVIDED BY A NON-PHYSICIAN
V2623	PROSTHETIC EYE, PLASTIC, CUSTOM
V2629	PROSTHETIC EYE, OTHER TYPE

There are no specified diagnoses or ICD-10 codes that indicate medical necessity.

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
    a. Member's name
    b. Date
    c. Description of item. The medical record must contain the information that supports the request for each item and must be submitted with the precertification, if the item requires precertification, or with the claim, if no precertification was required
    d. Order must include diagnosis code
    e. Physician signature with date. Date stamps are not appropriate
    f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

    The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request, usually with precertification per The Health Plan policy.

3. Proof of delivery to be kept on file by the provider of the item.

    Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), and all of the required information is not included, The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

    Note: Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

Precertification is required when supplies used are greater than the usual maximum quantity listed in above. There must be adequate, clear documentation in the medical record corroborating the medical necessity of this amount. This documentation is to be submitted with precertification.

FACIAL ORTHOSIS PROVIDED WHILE MEMBER IN PART A COVERED FACILITY

Facial prostheses provided in an inpatient hospital setting is reimbursed based on the contract and may or may not be separately billable as DME according to the individual facility's contract.

Implanted prosthesis anchoring components should not be billed separately as DME.

BILLING GUIDELINES

The following services and items are included in the allowance for a facial prosthesis and, therefore, are **not separately billable** to **or payable** under the prosthetic device benefit:

1. Evaluation of the patient
2. Preoperative planning
3. Cost of materials
4. Labor involved in the fabrication and fitting of the prosthesis
5. Modifications to the prosthesis made at the time of delivery of the prosthesis or within 90 days thereafter
6. Repair due to normal wear or tear within 90 days of delivery
7. Follow-up visits within 90 days of delivery of the prosthesis

Modifications to a prosthesis are separately payable when they occur more than 90 days after delivery of the prosthesis and they are required because of a change in the patient's condition.

If an ocular prosthesis is dispensed to the patient as an integral part of a facial prosthesis, the ocular prosthesis component must be billed by the supplier of the facial prosthesis (for information on ocular prostheses that are not part of orbital prostheses, refer to the medical policy on eye prostheses).

Claims for tape and adhesive (A4450, A4452, A5120) that are billed without an AV modifier or another modifier indicating coverage under a different policy will be denied as noncovered.

When a new ocular prosthesis component is provided as an integral part of an orbital, upper facial or hemi-facial prosthesis, it should be billed using code V2623 or V2629 on a separate claim line. When a replacement facial prosthesis utilizes an ocular component from the prior prosthesis, the ocular prosthesis code should not be billed.

When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and not separate codes for the orbit and the nose. This would apply even if the prosthesis is fabricated in two separate parts.

When codes A4450, A4452, and A5120 are used with a facial prosthesis, they must be billed with the AV modifier. For this policy, codes A4450, A4452, and A5120 are the only codes for which the AV modifier may be used.

Adhesives, adhesive remover, and tape used in conjunction with a facial prosthesis should be billed using codes A4364, A4455, A4456, A4450, or A4452. The unit of service is specified for each code. For tape, one unit of service is 18 sq. in. Therefore, a roll of tape ½ in. x 3 yds., would be three units; 1 in. x 3 yds would be six units. Other skin care products related to the prosthesis should generally not be billed, but if they are billed at the beneficiary's request, code A9270 (noncovered item or service) should be used.

The right (RT) and left (LT) modifiers should be used with facial prosthesis codes when applicable. Claims billed with codes L8042 - L8043 and L8045 - L8046, without modifiers RT and/or LT, will be rejected as incorrect coding.

KX, GA, and GZ MODIFIERS

Suppliers may submit a claim with a KX modifier only if all the criteria for that item is met.

If coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier, if they have not obtained a valid ABN.

ADVANCED BENEFICIARY NOTICE

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

NOTE: Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. dmepdac.com/

MEDICARE DEFINITIONS AND DESCRIPTION

A nasal prosthesis (L8040) is a removable superficial prosthesis, which restores all or part of the nose. It may include the nasal septum.

A mid-facial prosthesis (L8041) is a removable superficial prosthesis, which restores part or all of the nose plus significant adjacent facial tissue/structures, but does not include the orbit or any intraoral maxillary component. Adjacent facial tissue/structures include one or more of the following: soft tissue of the cheek, upper lip, or forehead.

An orbital prosthesis (L8042) is a removable superficial prosthesis, which restores the eyelids and the hard and soft tissue of the orbit. It may also include the eyebrow. This code does not include the ocular prosthesis component.

An upper facial prosthesis (L8043) is a removable superficial prosthesis, which restores the orbit plus significant adjacent facial tissue/structures, but does not include the nose or any intraoral maxillary component. Adjacent facial tissue/structures includes one or more of the following: soft tissue of the cheek or forehead. This code does not include the ocular prosthesis component.

A hemi-facial prosthesis (L8044) is a removable superficial prosthesis, which restores part or all of the nose plus the orbit and significant adjacent facial tissue/structures, but does not include any intraoral maxillary component. This code does not include the ocular prosthesis component.

An auricular prosthesis (L8045) is a removable superficial prosthesis, which restores all or part of the ear.

A partial facial prosthesis (L8046) is a removable superficial prosthesis which restores a portion of the face, but which does not specifically involve the nose, orbit, or ear.

A nasal septal prosthesis (L8047) is a removable prosthesis, which includes a hole in the nasal septum, but does not include superficial nasal tissue.

If a facial prosthesis has a component which is used to attach to a bone anchored implant or to an internal prosthesis (e.g., maxillary obturator), that component should be billed separately using code L8048. This code should not be used for implanted prosthesis anchoring components.

L8048 is also used for a facial prosthesis that is not described by a specific code, L8040 - L8047.

Code V2623 describes an ocular prosthesis, which is custom fabricated.

V2629 is used for an ocular prosthesis that is not custom fabricated. (i.e., stock prosthesis).

AMA CPT/ADA CDT COPYRIGHT STATEMENT

INTERNET LINKS AND SOURCES

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