

LCD for Facial Prostheses (L5046)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

LCD Information

LCD ID Number

L5046

LCD Title

Facial Prostheses

Contractor's Determination Number

FAC

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CMS National Coverage Policy

None

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

LCD Information

Oversight Region

Region I

DME Region LCD Covers

Jurisdiction A

Original Determination Effective Date

For services performed on or after 11/01/1996

Original Determination Ending Date

Revision Effective Date

For services performed on or after 01/01/2010

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare 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.

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

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

Coding Information

CPT/HCPCS Codes

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

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

Coding Information

KN - Replacement of facial prosthesis using previous master model

LT - Left side

RT - Right side

HCPCS CODES:

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, WIPES, ANY TYPE, EACH

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

ICD-9 Codes that Support Medical Necessity

Not specified.

Diagnoses that Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not specified.

General Information

Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

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 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 provided must be available upon request.

Refer to the Supplier Manual for more information on documentation requirements.

Appendices

Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Sources of Information and Basis for Decision

Advisory Committee Meeting Notes

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period

10/01/1996

General Information

Revision History Number

FACE005

Revision History Explanation

Revision Effective Date: 01/01/2010

HCPCS CODES AND MODIFIERS:

Replaced: A4365 with A4456.

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L5046 from DME PSC TriCenturion (77011) LCD L5046.

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Revised: Requirements for billing for codes L8048, V2629.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective date 01/01/2006

HCPCS CODES AND MODIFIERS:

Added: A5120

Deleted: A5119

Revision Effective date 04/01/2005

LMRP converted to LCD and Policy Article.

HCPCS CODES AND MODIFIERS:

Added: A5119

Revision Effective Date 04/01/2003

HCPCS CODES AND MODIFIERS:

Added: AV and EY modifiers, A4450, A4452

Deleted: K0572, K0573

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Standard language concerning coverage of items without an order

CODING GUIDELINES:

Moved: HCPCS definition to this section.

Added: Instruction for the AV modifier.

DOCUMENTATION REQUIREMENTS:

Added: Standard language concerning use of EY modifier for items without an order.

The revision date listed below is the date the revision was published and not necessarily the effective date for the revision.

07/01/2002 - Added codes A4364, A4365, K0572, K0573, L8040-L8049. Deleted codes K0440-K0449, K0265, K0450, K0451. Added LT and RT modifiers.

General Information

Reason for Change

Last Reviewed On Date

Related Documents

Article(s)

[A25186 - Facial Prostheses – Policy Article – Effective January 2010](#)

LCD Attachments

There are no attachments for this LCD

Article for Facial Prostheses – Policy Article – Effective January 2010 (A25186)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

Article Information

Article ID Number

A25186

Article Type

Article

Key Article

Yes

Article Title

Facial Prostheses – Policy Article – Effective January 2010

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island
Vermont

DME Region Article Covers

Jurisdiction A

Original Article Effective Date

04/01/2005

Article Information

Article Revision Effective Date

01/01/2010

Article Text

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES

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

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

- Evaluation of the patient
- Pre-operative planning
- Cost of materials
- Labor involved in the fabrication and fitting of the prosthesis
- Modifications to the prosthesis made at the time delivery of the prosthesis or within 90 days thereafter
- Repair due to normal wear or tear within 90 days of delivery
- 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.

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 a 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.

Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or 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.

Claims for facial prostheses from nonphysicians provided in an office or nursing home setting are submitted to the DME MAC. Claims for facial prostheses from physicians in these settings are submitted to the local carrier. Claims for facial prostheses provided in an outpatient hospital setting are submitted to the local intermediary. Facial prostheses provided in an inpatient hospital setting are included in the payment made to the hospital and therefore should not be submitted to the DME MAC. Implanted prosthesis anchoring components should not be billed to the DME MAC.

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.)

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

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.

CODING GUIDELINES

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

A midfacial 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 include 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 plus 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 occludes 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 it 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.

Code 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.

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

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

Article Information

using the hemi-facial prosthesis code and not separate codes for the orbit and 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.

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 noncovered and should not be coded as L8049.

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 square inches. Therefore, a roll of tape 1/2" X 3 yds. would be 3 units; 1" x 3 yds. would be 6 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/or left (LT) modifiers must be used with facial prosthesis codes when applicable. If bilateral prostheses using the same code are billed on the same date of service, the code should be entered on a single claim line using the RTL modifiers and billed with 2 units of service. Claims billed with codes L8042–L8043 and L8045–L8046, without modifiers RT and/or LT will be rejected as incorrect coding.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

Other Information

Revision History Explanation

Revision Effective Date: 01/01/2010

CODING GUIDELINES:

Replaced: A4365 with A4456

Revision Effective Date: 07/01/2009

CODING GUIDELINES:

Revised: RT/LT Modifier instructions.

Changed: SADMERC to PDAC.

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A25186 from DME PSC TriCenturion (77011) Article A25186.

Other Information

Revision Effective Date: 07/01/2007

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: DMERC references.

CODING GUIDELINES:

Removed: DMERC references.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 01/01/2006

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: A5120

Deleted: A5119

CODING GUIDELINES:

Added: A5120

Deleted: A5119

Revision Effective Date: 10/01/2005

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: A5119 to list of codes that require the AV modifier.

CODING GUIDELINES:

Added: A5119 to codes that require an AV Modifier.

Revision Effective Date: 04/01/2005

LMRP converted to LCD and Policy Article.

Related Documents

LCD(s)

[L5046 - Facial Prostheses](#)