MetroPlus Health

Policy and Procedure

Title: Facial Prosthetics	Division: Medical Management Department: Utilization Management
Approval Date: 6/16/2026	LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, GoldCare I&II, Market Plus, Essential, HARP
Effective Date: 4/1/2026	Policy Number: UM-MP 356
Review Date: 6/16/2026	Cross Reference Number:
Retired Date:	Page 1 of 4

1. POLICY DESCRIPTION:

This policy described the guidelines for coverage of Facial prosthetics, effective April 1st, 2026. These facial prosthetic codes are in addition to eye prosthetic services that were previously available under the vision benefit and are intended to support members who require facial prostheses due to congenital anomalies, traumas, or surgical intervention.

For the Medicare and UltraCare lines of business, MetroPlusHealth determines medical necessity based on applicable Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).
https://www.cms.gov/medicare-coverage-database/search.aspx

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

Facial Prosthetics- custom-made, external devices designed to restore the appearance and at times, function, of absent, disfigured, or malformed facial anatomy. These devices are typically made from medical-grade materials such as acrylic or silicone and are tailored to each member's unique facial structure.

COS 0405 - designates the Eye Prosthesis Fitter Category of Service for medical billing. As it pertains to this policy, it applies to an anaplastologist.

A**naplastologist**- a highly specialized healthcare professional who designs, sculpts, and fits custom-made, life-like prostheses. These custom prostheses help restore function, appearance, and confidence for patients following trauma, surgery, or congenital conditions.

4. POLICY:

A facial prosthesis is covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect when reconstruction surgery is not possible or desired by the member.

These service may only be provided by Providers enrolled under the category of service (COS) “0405” Facial/Eye Prosthesis Supplier and certified as an anaplastologist. Providers currently enrolled under COS 0405 who have been dispensing eye prosthetics may provide facial prosthetics if they possess this certification.

5. LIMITATIONS/ EXCLUSIONS:

Facial prosthetics supplied for reasons other than those described in this policy will be reviewed for medical necessity and may be deemed cosmetic.

6. APPLICABLE PROCEDURE CODES:

All codes listed below can only be billed by practitioners with the appropriate certification enrolled under Category of Service 0405 (Facial/Eye Prosthesis Supplier).

Authorization is required for the following procedures:

CPT	Description
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

Authorization is not required for the following procedures:

CPT	Description
L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT

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7. REFERENCE:

New York State Medicaid Provider Procedure Code Manual- Vision Care Procedure Code, April 2026
https://www.emedny.org/ProviderManuals/VisionCare/PDFS/VisionCare_Procedure_Codes.pdf

REVISION LOG:

REVISIONS	DATE
Creation date	6/16/2026

Approved: Date:	Approved: Date:
	Sanjiv Shah, MD Chief Medical Officer

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Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan 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). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program 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 MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.