

Facial Prostheses

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Health Equity Consideration

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Introduction

Facial prostheses are addressed in the guideline.

Criteria

A facial prosthesis is considered medically necessary when used to replace or restore facial structures that are absent or deficient due to disease, trauma, surgical intervention, or a congenital condition.

Not Medically Necessary

Duplicate external facial prostheses are considered convenience items and are therefore considered not medically necessary.

Note:

Implanted components are not considered durable medical equipment (DME) and are therefore billed separately.

Modifications and Repairs

Modifications to a prosthesis may be separately reimbursed when performed more than 90 days after initial delivery and when necessitated by a change in the individual's clinical condition (e.g., weight gain or loss, additional tumor resection or reconstructive

surgery that results in altered facial contours or ongoing healing, scar contracture, or tissue remodeling after surgery causes the existing prosthesis to no longer fit properly).

Repairs to a prosthesis are considered medically necessary when required due to accidental damage or significant wear (e.g., clinically meaningful compromise of fit or function) that can be corrected. If the cost of repair exceeds the anticipated cost of replacement, reimbursement is limited to the cost of a replacement prosthesis.

Replacement Prostheses

Replacement of a facial prosthesis is considered medically necessary when the existing prosthesis is no longer serviceable due to irreparable deterioration affecting function, retention, or cosmetic acceptability or cannot be restored to acceptable function and appearance through repair. Replacement is considered medically necessary based on clinical deterioration and reasonable useful lifetime. Routine replacement based solely on elapsed time is considered not medically necessary.

Evidence Discussion

In a 2025 systematic review (Ghagas et al.), the authors evaluated functional outcomes and quality of life following maxillofacial prosthetic rehabilitation by synthesizing data from 24 studies published through November 2023. The included studies represented a combined sample of 1,158 individuals, including 798 with maxillary defects, 267 with mandibular defects, and 93 with facial defects. Across the included literature, prosthetic rehabilitation was consistently associated with improvements in functional outcomes such as speech, mastication, and overall daily functioning, as well as enhancements in quality of life measures. Although a formal meta-analysis was not feasible due to heterogeneity in study designs, populations, and outcome measures, the overall findings demonstrated a positive trend toward improved well-being following prosthetic use. The authors concluded that maxillofacial prosthetic rehabilitation resulted in meaningful improvements in function and quality of life, supporting its role as an effective intervention for individuals with facial and oral defects. However, the review identified several limitations, including variability in outcome measurement tools, heterogeneity of study methodologies, and the lack of standardized assessment instruments, which limited comparability across studies and the strength of pooled conclusions.

In a 2025 retrospective case series by Chatterjee et al., of 13 individuals with advanced head and neck cancer who underwent facial prosthetic rehabilitation after flap failure, the use of extraoral prostheses was associated with statistically significant improvements in quality of life outcomes over a 6-month period. Specifically, psychosocial perception scale scores demonstrated significant improvement in functional domains ($p = 0.05$) and positive emotional domains ($p = 0.04$), indicating

that individuals were better able to perform daily and social activities and reported increased enthusiasm and confidence following prosthesis use. Additional domains, including aesthetics, negative emotions, and interpersonal relationships, showed marginal but not statistically significant improvement. Nearly all individuals (12 of 13) used magnet-retained silicone prostheses, and the majority were able to manage the prosthesis independently in their home environment after fitting. Functional gains were further suggested by the removal of nasogastric tubes in most cases within two weeks, indicating improvement in oral intake. The authors concluded that facial prostheses served as an effective salvage intervention that improved function and psychosocial well-being, were relatively easy for individuals to handle independently, and reduced the need for prolonged hospital-based care, supporting their role in ongoing daily use outside the clinical setting. Study limitations included the small sample size, retrospective design, selection of only motivated and compliant individuals, and restriction to limited retention methods due to financial constraints, which may limit generalizability.

In a 2024 prospective cohort study by Chiba et al. of 112 individuals who underwent surgical treatment for head and neck tumors followed by maxillofacial prosthetic rehabilitation, prosthetic use was associated with statistically significant improvements in oral health-related quality of life and masticatory function after the postoperative period. Quality of life initially worsened after surgery but improved following prosthetic treatment, with significant differences observed across time periods ($p < 0.05$), indicating recovery attributable to prosthetic intervention. Similarly, both subjective food intake status scores and objective gum-jelly test scores declined after surgery and subsequently improved after prosthetic placement, with significant differences across time points ($p < 0.05$), reflecting improved chewing ability and oral function. Multivariate analysis identified maxillary defects, tongue and soft tissue defects, and receipt of chemoradiotherapy as factors associated with poorer outcomes, while reconstructive surgery was associated with improved functional and quality of life measures. The authors concluded that maxillofacial prosthetic treatment contributed to meaningful recovery in function and quality of life following surgical resection and should be integrated with surgical reconstruction when possible. Study limitations included restriction to a single-center cohort, exclusion of individuals with more severe dysphagia or aspiration risk, and variability in defect types and treatments, which may limit generalizability.

Codes

HCPCS code descriptions

HCPCS Code	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
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

References

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