Molina Clinical Policy
Criteria for Maxillofacial Prosthetics
Policy No. 16.14
Last Approval: 05/23/2025

DISCLAIMER

The clinical criteria outlined is generalized. Services described may not be covered for a particular plan type. In addition, there may be additional plan specific criteria regarding treatment. Therefore, it is essential dental providers review the Benefits Covered Section of the Office Reference Manual (ORM) before providing any treatment.

OVERVIEW

The criteria outlined is based on procedure codes as defined in the American Dental Association's Code Manuals[1]. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for review, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as guidelines for review and payment decisions and are not intended to be all-inclusive or absolute.

It is also recognized that "local community standards of care" may vary from region to region and incorporate generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards.

Prior authorization and post-service review prior to payment are common methods of ensuring medical necessity for payment. Prior Authorization and post-service review are more effective than pay-and-chase processes and preferrable to recoupment.

Clinical review (prior authorization or post-service) is necessary for maxillofacial prosthetics to protect the program and members by confirming the necessity, prognosis, and appropriateness of the procedure, especially due to the infrequent use of maxillofacial prosthetics. Maxillofacial prosthetics are commonly reviewed by other Medicaid dental insurance programs for necessity/adherence to clinical criteria.

COVERAGE POLICY

Documentation needed for review of procedure:

- Narrative describing medical necessity
- X-rays

Criteria

Maxillofacial prosthetics must be medically necessary.

CODING & BILLING INFORMATION

CDT (Current Dental Terminology) Codes

Code	Description	Authorization Required	Frequency Limitations
D5913	nasal prosthesis	Prior Auth or Post-Service	None
D5914	auricular prosthesis	Prior Auth or Post-Service	
D5919	facial prosthesis	Prior Auth or Post-Service	
D5931	obturator prosthesis, surgical	Prior Auth or Post-Service	
D5932	obturator prosthesis, definitive	Prior Auth or Post-Service	

D5934	mandibular resection prosthesis with guide flange	Prior Auth or Post-Service	
D5952	speech aid prosthesis, pediatric	Prior Auth or Post-Service	
D5953	speech aid prosthesis, adult	Prior Auth or Post-Service	
D5954	palatal augment prosthesis	Prior Auth or Post-Service	
D5955	palatal lift prosthesis, definitive	Prior Auth or Post-Service	
D5988	surgical splint	Prior Auth or Post-Service	

CODING DISCLAIMER. Services described may not be covered for a particular plan type. In addition, there may be additional plan specific criteria regarding treatment. Therefore, it is essential dental providers review the Benefits Covered Section of the Office Reference Manual (ORM) before providing any treatment.

APPROVAL HISTORY

04/02/2025 Policy reviewed and approved.
05/23/2025 Updated policy reviewed and approved.

REFERENCES

1. American Dental Association's Code Manuals (https://www.ada.org/publications/cdt)