

1 **Clinical Practice Guideline: Nail Avulsion**

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3 **Date of Implementation: June 18, 2015**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers services consisting of CPT®
 10 Codes 11730, 11732, 11750, and 11765 to be medically necessary for surgical management
 11 of complicated/symptomatic ingrowing nail(s)/nail avulsion **upon meeting ALL of the**
 12 **following criteria:**

- 13 1. The patient must have **1 or more** of the following conditions (applicable codes
 14 listed below):
- 15 ○ Ingrowing nail
 - 16 ○ Onychia and paronychia of toe
 - 17 ○ Dermatophytosis of nail (onychomycosis)
 - 18 ○ Cellulitis and abscess of unspecified digit
 - 19 ○ Other specified diseases of nail (dystrophia unguinum, dystrophic nail)
 - 20 ○ Unspecified disease of nail
 - 21 ○ Crushing injuries of nails and/or toes with resultant hematoma
 - 22 ○ Complicated wounds of the toes involving nail components
- 23 2. The toe is characterized by **1 or more** of the following:
- 24 ○ Pain
 - 25 ○ Inflammation of the nail bed
 - 26 ○ Inflammation of the surrounding soft tissue
 - 27 ○ Infection and/or
 - 28 ○ Subungual abscess
- 29 3. The affected nail has caused a marked limitation in ambulation or function or
 30 otherwise jeopardizes the integrity of the toe.

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32 **ICD-10 Codes and Descriptions**

ICD-10 Code	ICD-10 Code Description
B35.1	Tinea unguium
L02.611 - L02.619	Cutaneous abscess of foot
L03.031 - L03.049	Cellulitis of toe – acute lymphangitis of toe
L60.0	Ingrowing nail
L60.1	Onycholysis
L60.2	Onychogryphosis

ICD-10 Code	ICD-10 Code Description
L60.3	Nail dystrophy
L60.4	Beau's lines
L60.5	Yellow nail syndrome
L60.8	Other nail disorders
L60.9	Nail disorder, unspecified
L62	Nail disorders in diseases classified elsewhere
Q84.4	Congenital leukonychia
Q84.5	Enlarged and hypertrophic nails
Q84.6	Other congenital malformations of nails
S91.201A - S91.259S	Unspecified open wound, laceration, open bite, or puncture of toe(s) with damage to nail, initial encounter through sequela
S96.929A - S96.929S	Laceration of unspecified muscle and tendon at ankle and foot level, unspecified foot, initial encounter through sequela
S90.211A - S90.229S	Contusion of toe(s) with damage to nail, initial encounter through sequela
S97.101A- S97.129S	Crushing injury of toe(s), initial encounter through sequela
T25.331A - T25.339S, T25.731A - T25.739S	Burn or corrosion of third degree of toe(s) (nail)

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2 Treatment of simple uncomplicated or asymptomatic ingrowing nail by removal of the
3 offending nail spicule not requiring local anesthesia is considered to be routine foot care as
4 are other trimming, cutting, clipping and debriding of a nail distal to the eponychium.

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6 Refer to ASH's *Routine Foot Care (CPG 218 – S)* or *Routine Foot Care: Medicare*
7 *Advantage Supplement (CPG 302 – S)* clinical practice guideline for routine foot care
8 guidelines.

9

10 An ingrown nail is growth of the nail edge into the surrounding soft tissue that may result
11 in pain, inflammation, or infection. This condition most commonly occurs in the great toes
12 and may require surgical management. Other conditions may also require avulsion of the
13 entire nail or a portion of a nail. This policy describes conditions under which ASH
14 payment for nail avulsion may be made.

1 **CPT® Codes and Descriptions**

CPT® Code	CPT® Code Description
11730	Avulsion of nail plate, partial or complete, simple; single
11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate (list separately in addition to code for primary procedure)
11750	Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail), for permanent removal
11765	Wedge excision of skin of nail fold (e.g., for ingrown toenail)

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3 **BACKGROUND**

4 The nail is a complex unit composed of five major modified cutaneous structures: the nail
5 matrix, nail plate, nail bed, cuticle (eponychium), and nail folds. The cuticle is an
6 outgrowth of the proximal fold and is situated between the skin of the digit and the nail
7 plate, fusing these structures together. This configuration provides a waterproof seal from
8 external irritants, allergens, and pathogens. However, invasive inflammatory or infectious
9 conditions can affect the nail and have a marked impact on a patient’s quality of life. Wedge
10 excision of the skin of the nail fold to alleviate symptoms associated with inflammatory or
11 infectious conditions of the nail fold is addressed within the context of this clinical practice
12 guideline.

13

14 Ingrown toenails (unguis incarnatus) are a common toenail problem. Ingrown toenails
15 occur when the periungual skin is punctured or traumatized by one of the distal angles of
16 the nail plate resulting in a cycle of invasion of foreign bodies, which is sometimes
17 followed by infection with signs of inflammation. Various causes include poorly fit (i.e.,
18 tight) footwear, infection, improperly trimmed toenails, trauma, and heredity. If ingrown
19 toenails are recognized early, before infection sets in, conservative treatment options are
20 available. These include home care such as soaking the foot in warm water 3-4 times daily
21 for 2-14 days, ensuring the foot remains dry for the remainder of the day, wearing
22 comfortable shoes with adequate room for the toes, and applying steroid cream or ointment
23 to the affected area (Mayeaux et al., 2019). However, if excessive inflammation, swelling,
24 pain, and discharge are present, indicating infection, then the surgical excision of the nail
25 should be considered. Furthermore, Eekhof et al. (2012) conducted a review of the
26 literature and concluded that surgical interventions are more effective than non-surgical

1 interventions in preventing the recurrence of an ingrowing toenail. The following surgical
2 procedures represent the options used to treat complicated/symptomatic ingrowing nail(s):

- 3 • Avulsion of a nail (CPT® codes 11730 and 11732) involving separation and
4 removal of the entire nail plate or a portion of nail plate, including the entire length
5 of the nail border to and under the eponychium. A nail avulsion usually requires
6 injected local anesthesia except in instances wherein the digit is devoid of sensation
7 or there are other extenuating circumstances for which injectable anesthesia is not
8 required or is medically contraindicated.
- 9 • Excision of the nail and the nail matrix (CPT® code 11750) performed under local
10 anesthesia requiring separation and removal of the entire nail plate or a portion of
11 nail plate, including the entire length of the nail border to and under the
12 eponychium, followed by destruction or permanent removal of the associated nail
13 matrix.
- 14 • Wedge excision of the nail fold hypertrophic granulation tissue with removal of the
15 offending portion of the nail (CPT® code 11765).

16
17 Regrowth of the nail usually requires at least four months. With appropriate surgical
18 management and instruction for proper shoes and nail care, the problem of ingrowing nails
19 should not recur.

20
21 Other conditions may also require avulsion of the entire nail or portion of a nail. Paronychia
22 is an inflammation of the folds of tissue surrounding the nail of a toe or finger. Paronychia
23 may be classified as either acute or chronic. The main factor associated with the
24 development of acute paronychia is direct or indirect trauma to the cuticle or nail fold. This
25 enables pathogens to inoculate the nail, resulting in infection. Conservative treatment
26 options for acute paronychia include warm compresses; topical antibiotics, with or without
27 corticosteroids; oral antibiotics. Surgical incision and drainage is recommended for more
28 severe cases and in recalcitrant chronic paronychia, en bloc excision of the proximal nail
29 fold is an option. (Rigopoulos et al., 2008).

30
31 Onychomycosis accounts for half of all nail pathologies. Onychomycosis is a fungal
32 infection caused by various pathogens (e.g., dermatophytes). Distal and lateral subungual
33 onychomycosis is the most common presentation of dermatophyte nail infection. In this
34 onychomycosis pattern, the fungus invades the nail and nail bed by invading the distal and
35 lateral margins. The affected nail becomes thickened and discolored, with varying degrees
36 of onycholysis (separation of the nail plate from the nail bed), and in time the nail plate
37 becomes friable and may break apart. The clinical characteristics of dystrophic nails should
38 alert the physician of the possibility of onychomycosis, however, confirmation of a clinical
39 diagnosis via mycological and histological examination should be performed on patients
40 with lesions of undetermined origin (Ameen et al., 2014).

1 Gupta et al. (2013) carried out a systematic review of the literature to evaluate treatments
 2 for onychomycosis and determined that surgical avulsion can be performed both distally
 3 and proximally. Distal avulsion is normally undertaken, when feasible. The procedure is
 4 generally followed by treatment with antifungals, and better results are obtained when
 5 topical antifungals are used under occlusion. The advantages of this procedure are that it
 6 reduces fungal mass and provides material from the nail plate, the nail bed, or both for
 7 more accurate diagnosis, but cautioned that the surgical procedure may result in
 8 complications such as shrinking of the nail bed, dorsal dislocation, distal paronychia, and
 9 infection. The researchers recommended surgical avulsion as an option for cases that are
 10 resistant to topical and systemic antifungals.

11 **PRACTITIONER SCOPE AND TRAINING**

12 Practitioners should practice only in the areas in which they are competent based on their
 13 education, training, and experience. Levels of education, experience, and proficiency may
 14 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
 15 to determine where they have the knowledge and skills necessary to perform such services
 16 and whether the services are within their scope of practice.
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18
 19 It is best practice for the practitioner to appropriately render services to a member only if
 20 they are trained, equally skilled, and adequately competent to deliver a service compared
 21 to others trained to perform the same procedure. If the service would be most competently
 22 delivered by another health care practitioner who has more skill and training, it would be
 23 best practice to refer the member to the more expert practitioner.
 24

25 Best practice can be defined as a clinical, scientific, or professional technique, method, or
 26 process that is typically evidence-based and consensus driven and is recognized by a
 27 majority of professionals in a particular field as more effective at delivering a particular
 28 outcome than any other practice (Joint Commission International Accreditation Standards
 29 for Hospitals, 2020).
 30

31 Depending on the practitioner's scope of practice, training, and experience, a member's
 32 condition and/or symptoms during examination or the course of treatment may indicate the
 33 need for referral to another practitioner or even emergency care. In such cases it is prudent
 34 for the practitioner to refer the member for appropriate co-management (e.g., to their
 35 primary care physician) or if immediate emergency care is warranted, to contact 911 as
 36 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
 37 guideline for information.
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