Clinical Practice Guideline: **Repair or Reconstruction of Nail Bed**

Date of Implementation: **October 15, 2015**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Codes 11760 and 11762 to be medically necessary for reconstruction of nail bed with graft **upon meeting ALL of the following criteria**:

1. Traumatic injury to the toe
2. The wound is not healing with wound care OR is too damaged to heal properly

Surgery performed solely for the purpose of improving the appearance of the foot carries risks without medical benefit, and therefore is considered not medically necessary.

CPT CODES AND DESCRIPTIONS

CPT® Code	CPT® Code Description
11760	Repair of nail bed
11762	Reconstruction of nail bed with graft

BACKGROUND

CPT code 11760 describes procedure for repair of the nail bed. CPT code 11762 describes procedures for reconstruction of nail bed with graft. A nail bed graft is obtained from the nail bed of an adjacent area or from the great toe's nail bed and sutured into place, covering the defect.

Nail loss or deformity is not only unaesthetic in appearance but can be functionally incapacitating. A proper knowledge and understanding of nail anatomy is essential for proper treatment of various conditions affecting it.

The most common cause of acute and chronic nail bed deformity is trauma. These injuries can be either open or closed and can push the nail bed between the hard nail and distal phalanx, resulting in simple or complex lacerations. Sharp lacerations can occur when objects land with enough force to penetrate the nail plate. Avulsion injuries can result from crush or grinding type injuries and can lead to partial loss of nail bed. Iatrogenic injuries can occur from traumatic nail plate removal for procedures or during placement of K wires. Self-inflicted injuries can also occur, such as injuries from self nail care or pedicures.

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Reconstruction of Nail Bed
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Proper management of these injuries is essential not only for quick healing, but also to prevent complications and the resultant late deformities (Bharathi & Bajantri, 2011).

The likelihood of achieving a satisfactory functional result following acute care decreases substantially with nail bed avulsion injuries, phalangeal degloving and partial digital amputations. Rosenthal classified nail bed injuries according to the level and direction of tissue loss. The three levels of injury include: zone I, distal to the distal phalanx; zone II, distal to the lunula; and zone III, proximal to distal end of the lunula. The direction of tissue loss is classified as dorsal oblique, transverse, plantar oblique, tibial or fibular axial, or central (gouging). Zone I lesions typically do not incur bony defects and can often heal without surgical intervention. Surgeons have described a variety of skin grafting procedures for lesions measuring greater than 1 cm^2. Zone II injuries are amenable to closure using local advancement flaps in the form of the Atasoy V-to-Y flap and the Kutler biaxial medial and lateral V-flap advancements. The goal of soft tissue advancement is coverage of the distal phalanx, which may itself require debridement and remodeling of the distal margin in order to enable adequate soft tissue coverage. If an excessive amount of the nail bed has been lost (proximal zone II and zone III injuries) and subsequent nail plate instability is anticipated (less than 5 mm of remaining intact nail bed), then the surgeon should consider ablation of the inadequate residual nail bed and reconstruction of the digital tip by means of distal interphalangeal joint disarticulation. Zone III injuries are generally not considered suitable for nail bed reconstruction and complete matrix excision is recommended (Malay, 2006; Bharathi & Bajantri, 2011).

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

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

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

References

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