Clinical Practice Guideline: **Nail Avulsion**

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Product: **Specialty**

GUIDELINES

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

1. The patient must have **1 or more** of the following conditions (applicable codes listed below):
   - Ingrowing nail
   - Onychia and paronychia of toe
   - Dermatophytosis of nail (onychomycosis)
   - Cellulitis and abscess of unspecified digit
   - Other specified diseases of nail (dystrophia ungulum, dystrophic nail)
   - Unspecified disease of nail
   - Crushing injuries of nails and/or toes with resultant hematoma
   - Complicated wounds of the toes involving nail components
2. The toe is characterized by **1 or more** of the following:
   - Pain
   - Inflammation of the nail bed
   - Inflammation of the surrounding soft tissue
   - Infection and/or
   - Subungal abscess
3. The affected nail has caused a marked limitation in ambulation or function or otherwise jeopardizes the integrity of the toe.

ICD-10 Codes and Descriptions That Support Medical Necessity

ICD-10 Codes	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

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L60.3	Nail dystrophy
L60.4	Beau's lines
L60.5	Yellow nail syndrome
L60.8	Other nail disorders
L60.9	Nail order, 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)

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

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

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

CPT CODES AND DESCRIPTIONS

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)

BACKGROUND

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

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

toenail. The following surgical procedures represent the options used to treat complicated/symptomatic ingrowing nail(s):

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

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

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

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

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

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.

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