

FUTURE Local Coverage Determination (LCD): Surgical Treatment of Nails (L34887)

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Please note: Future Effective Date.

Contractor Information

Contractor Name Novitas Solutions, Inc. Back to Top	Contract Number 04412	Contract Type A and B MAC	Jurisdiction J - H
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LCD Information

Document Information



LCD ID

L34887

Original ICD-9 LCD ID
[L27532](#)

LCD Title
Surgical Treatment of Nails

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Jurisdiction
Texas

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CMS National Coverage Policy This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for nail avulsion services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for nail avulsion services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding nail avulsion services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

- *Medicare Benefit Policy Manual* - Pub. 100-02, Chapter 15, Section 290.
- *Medicare National Coverage Determinations Manual* - Pub. 100-03, Part 1, Section 70.2.1.
- *Correct Coding Initiative - Medicare Contractor Beneficiary and Provider Communications Manual* - Pub. 100-09, Chapter 5.
- Social Security Act (Title XVIII) Standard References:
 - Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
 - Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
 - Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.
 - Title XVIII of the Social Security Act, Section 1862(a)(13)(C) addresses routine foot care.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described in this entire LCD) as covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

An ingrown nail is a condition which results in the 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 the nail. This policy addresses those conditions under which Medicare payment for nail avulsion may be made.

Treatment of simple uncomplicated or asymptomatic aberrant growing nail by removal of a nail spicule, not requiring local anesthesia, is considered to be routine foot care when the involved nail is on the foot. Trimming, cutting, clipping, and debriding of a nail distal to the eponychium of the toes are considered routine foot care. Routine foot care is only covered when certain systemic conditions are present. Routine foot care should be coded with *G0127* and *11719*, *11720*, and *11721*.

Only in rare instances should *11730/11732/11750/11755/11765* be billed for treatment of upper extremity digits and will be subject to review for medical necessity.

Routine foot care should **NOT** be coded with *11730* or *11732*. Please refer to LCD L27486, Routine Foot Care and

to LCD L27487, Debridement of Mycotic Nails for additional information.

Avulsion of a nail plate (CPT codes *11730* and *11732*) is, generally, performed under local anesthesia. This procedure involves the separation and removal of a border of the nail or removal of the entire nail from the nail bed to the eponychium.

Excision of nail and nail matrix (CPT code *11750*) is performed under local anesthesia and requires removal of part or all of the nail thickness and length, with destruction or permanent removal of the matrix (e.g., chemical/surgical matrixectomy).

Wedge excision of skin of nail fold (CPT code *11765*) is designed to relieve pressure on the nail/soft tissue and requires an excision of a wedge of the soft tissue and ingrown nail from the involved side of the toe.

Indications

Surgical treatment of nails is covered for the following indications:

- Ingrown toenails
- Subungual abscess
- Onychogryposis or onychauxis
- Deformed nails that prevent wearing shoes or otherwise jeopardize the integrity of the toe

Nail avulsions usually offer only temporary relief for ingrown toenails. The nail often grows back to its original thickness and the offending margin again may become problematic, resulting in another nail avulsion. Therefore, a partial or complete excision of nail and nail matrix may be the preferred course of treatment for recurrent ingrown nails. When a nail avulsion is done, another avulsion should not be required for at least 12 weeks.

Limitations

The following indications are non-covered because they are considered routine foot care:

- Removing small chips or wedges of the nail or skin
- Excising less than the full thickness, width or length of the affected nail
- Simple treatment of ingrown toenails (e.g., trimming, cutting, clipping of the distal unattached nail margins)

Medicare payment of CPT codes *11730* and *11732* in places of service other than hospitals or ambulatory surgical centers is limited to 5 services (one of *11730* and 4 of *11732*) per day. It is expected that very few patients would require as many as 5 services in one day, and no patient should require hospitalization or more than local anesthesia for these services. On the occasion that a patient is hospitalized for a covered medical condition, requiring anesthesia, there is no restriction to the number of services performed while under anesthesia for treatment of that medical condition.

As published in CMS IOM 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
- Furnished in a setting appropriate to the patient's medical needs and condition.
- Ordered and furnished by qualified personnel.
- One that meets, but does not exceed, the patient's medical needs.
- At least as beneficial as an existing and available medically appropriate alternative.

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology (CPT)* codes.

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Coding Information

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Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

012x Hospital Inpatient (Medicare Part B only)
 013x Hospital Outpatient
 014x Hospital - Laboratory Services Provided to Non-patients
 018x Hospital - Swing Beds
 021x Skilled Nursing - Inpatient (Including Medicare Part A)
 022x Skilled Nursing - Inpatient (Medicare Part B only)
 023x Skilled Nursing - Outpatient
 028x Skilled Nursing - Swing Beds
 071x Clinic - Rural Health
 075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
 083x Ambulatory Surgery Center
 085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

NOTE: The contractor has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all the CPT/HCPCS codes listed can be billed with all the Bill Types and/or Revenue codes listed. Providers are encouraged to refer to the CMS Internet-Only Manual (IOM) Pub. 100-04 Claims Processing Manual, for further guidance.

031X Laboratory Pathology - General Classification
 036X Operating Room Services - General Classification
 0450 Emergency Room - General Classification
 0500 Outpatient Services - General Classification
 0509 Outpatient Services - Other Outpatient Service
 051X Clinic - General Classification
 052X Freestanding Clinic - General Classification
 076X Specialty Services - General Classification

CPT/HCPCS Codes

Group 1 Paragraph: Note: Providers are reminded to refer to the long descriptors of the CPT codes in the CPT Code book.

Group 1 Codes:

- 11730 Removal of nail plate
- 11732 Remove nail plate add-on
- 11750 Removal of nail bed
- 11765 Excision of nail fold toe

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

The CPT/HCPCS codes included in this LCD will be subjected to "procedure to diagnosis" editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for **CPT/HCPCS codes 11730, 11732, 11750, and 11765:**

Group 1 Codes:

ICD-10 Codes	Description
B35.1	Tinea unguium
L03.031	Cellulitis of right toe
L03.032	Cellulitis of left toe
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L60.0	Ingrowing nail
L60.1	Onycholysis
L60.2	Onychogryphosis
L60.3	Nail dystrophy
L60.4	Beau's lines
L60.5	Yellow nail syndrome
L60.8	Other nail disorders
L62	Nail disorders in diseases classified elsewhere
Q84.3	Anonychia
Q84.4	Congenital leukonychia
Q84.5	Enlarged and hypertrophic nails
Q84.6	Other congenital malformations of nails
T25.331A	Burn of third degree of right toe(s) (nail), initial encounter
T25.332A	Burn of third degree of left toe(s) (nail), initial encounter
T25.731A	Corrosion of third degree of right toe(s) (nail), initial encounter
T25.732A	Corrosion of third degree of left toe(s) (nail), initial encounter

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph: All those not listed under the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Group 1 Codes: N/A

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General Information

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Associated Information

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. Surgical treatment of nails, in general, requires the use of local anesthesia. The medical record must indicate the anesthesia used (digital, local or topical). If digital or local anesthesia is not used, it must be clear, in the medical record, why (e.g., "patient requested topical anesthesia", "patient allergic to lidocaine", or "patient has neuropathy precluding need for anesthesia", etc.).
6. It is inappropriate to state "no anesthesia used due to a possible anesthetic reaction" without indicating the patient's allergies in the medical record.
7. For procedure codes *11730*, *11732*, *11750*, and *11765* an operative report or complete detailed description of the procedure being performed is required. Documentation must support the medical necessity and the frequency of the service. Failure to include the following information in the patient's medical record could result in denial of the claim.
 - The patient's chief complaint (e.g., painful toe)
 - Procedure being performed (making note to the nail margin involved)
 - Method of obtaining anesthesia (if not used, the reason for not using it)
 - A complete detailed description of the procedure
 - Postoperative observation and treatment of the surgical site (e.g., minimal bleeding, sterile dressing applied)
 - Postoperative instructions given to the patient and any follow-up care (e.g., soaks, antibiotics, follow-up appointments)

Additional Information

Please refer to the Local Coverage Article for Surgical Treatment of Nails, for additional information.

Appendices

N/A

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Services performed to the same nail more often than every 12 weeks are considered to be not medically reasonable and necessary.

Nail Avulsion and Routine Nail trimming will not be allowed on the same nail on the same day.

Services totaling greater than 10 of combined *11730* and *11732* per 12 months will be denied as not medically reasonable and necessary.

Notice: This LCD imposes utilization guideline limitations. Despite Medicare's allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Sources of Information and Basis for Decision
Novitas Solutions JH LCD L32637, Nail Avulsion

Contractor is not responsible for the continued viability of websites listed.

Other Contractor's Policies

Contractor Medical Directors

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[Revision History Information](#)

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/01/2015	R1	LCD revised and published on 06/25/2015.	<ul style="list-style-type: none">• Creation of Uniform LCDs With Other MAC Jurisdiction• Revisions Due To ICD-10-CM Code Changes

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[Associated Documents](#)

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

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[Keywords](#)

N/A Read the [LCD Disclaimer](#) [Back to Top](#)