

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

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3 **Date of Implementation: October 15, 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 11760 and 11762 to be medically necessary for reconstruction of nail bed with graft
 11 **upon meeting ALL of the following criteria:**

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

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18 **CPT® Codes and Descriptions**

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

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20 **DESCRIPTION/BACKGROUND**

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

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

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

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

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 4 The likelihood of achieving a satisfactory functional result following acute care decreases
 5 substantially with nail bed avulsion injuries, phalangeal degloving and partial digital
 6 amputations. Rosenthal classified nail bed injuries according to the level and direction of
 7 tissue loss. The three levels of injury include: zone I, distal to the distal phalanx; zone II,
 8 distal to the lunula; and zone III, proximal to distal end of the lunula. The direction of tissue
 9 loss is classified as dorsal oblique, transverse, plantar oblique, tibial or fibular axial, or
 10 central (gouging). Zone I lesions typically do not incur bony defects and can often heal
 11 without surgical intervention. Surgeons have described a variety of skin grafting
 12 procedures for lesions measuring greater than 1 cm². Zone II injuries are amenable to
 13 closure using local advancement flaps in the form of the Atasoy V-to-Y flap and the Kutler
 14 biaxial medial and lateral V-flap advancements. The goal of soft tissue advancement is
 15 coverage of the distal phalanx, which may itself require debridement and remodeling of
 16 the distal margin in order to enable adequate soft tissue coverage. If an excessive amount
 17 of the nail bed has been lost (proximal zone II and zone III injuries) and subsequent nail
 18 plate instability is anticipated (less than 5 mm of remaining intact nail bed), then the
 19 surgeon should consider ablation of the inadequate residual nail bed and reconstruction of
 20 the digital tip by means of distal interphalangeal joint disarticulation. Zone III injuries are
 21 generally not considered suitable for nail bed reconstruction and complete matrix excision
 22 is recommended (Malay, 2006; Bharathi & Bajantri, 2011).

23 24 **PRACTITIONER SCOPE AND TRAINING**

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

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

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

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

8 9 **References**

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