https://www.novitas-solutions.com/policy/mac-ab/l27532-r8.html

LCD L27532 - Surgical Treatment of Nails

Contractor Information

Contractor Name:

Novitas Solutions, Inc.

Contractor Number(s):

12102, 12202, 12302, 12501, 12301, 12201, 12401, 12402, 12101, 12502, 12901

Contractor Type:

MAC Part A & B

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LCD Information

Document Information

LCD ID Number

L27532

LCD Title

Surgical Treatment of Nails

Contractor's Determination Number

L27532

AMA CPT/ADA CDT Copyright Statement

Primary Geographic Jurisdiction

Pennsylvania, Maryland, District of Columbia, New Jersey, Delaware

Oversight Region

Central Office

Original Determination Effective Date

For services performed on or after 07/11/2008

Original Determination Ending Date

N/A

Revision Effective Date

For services performed on or after 04/02/2012

Revision Ending Date

N/A

CMS National Coverage Policy

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.

Indications and Limitations of Coverage and/or Medical Necessity

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 ingrowing nail by removal of the offending nail spicule, not requiring local anesthesia, is considered to be routine foot care. Trimming, cutting, clipping, and debriding of a nail distal to the eponychium are also considered routine foot care. Routine foot care is only covered when certain systemic conditions are present. Routine foot care should NOT be coded with 11730/11732 but rather with G0127 and 11719-11721 Please review LCDs Coverage Requirements for Routine Foot Care and 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 along its 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

Paronychia

Subungal abscess

Onychogryposis or onychauxis

Contusion injury of the fingers or toes

Crushing injury of the fingers or toes

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:

Cutting small chips

Excising less than the full length of the affected nail

Simple treatment of ingrown toenails (e.g., trimming, cutting, clipping of the distal unattached nail margins)

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Coding Information

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.

011x

Hospital Inpatient (Including Medicare Part A)

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

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.

031X

Laboratory Pathology - General Classification

036X

Operating Room Services - General Classification

051X

Clinic - General Classification

076X

Specialty Services - General Classification

CPT/HCPCS Codes

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

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 (EG, INGROWN OR DEFORMED NAIL), FOR PERMANENT REMOVAL;

11765

WEDGE EXCISION OF SKIN OF NAIL FOLD (EG, FOR INGROWN TOENAIL)

ICD-9 Codes that Support Medical Necessity

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

110.1

DERMATOPHYTOSIS OF NAIL

681.02

ONYCHIA AND PARONYCHIA OF FINGER

681.10

UNSPECIFIED CELLULITIS AND ABSCESS OF TOE

681.11

ONYCHIA AND PARONYCHIA OF TOE

681.9

CELLULITIS AND ABSCESS OF UNSPECIFIED DIGIT

696.1

OTHER PSORIASIS AND SIMILAR DISORDERS

703.0

INGROWING NAIL

703.8

OTHER SPECIFIED DISEASES OF NAIL

703.9

UNSPECIFIED DISEASE OF NAIL

757.5

SPECIFIED CONGENITAL ANOMALIES OF NAILS

883.1

OPEN WOUND OF FINGERS COMPLICATED

883.2

OPEN WOUND OF FINGERS WITH TENDON INVOLVEMENT

893.0 - 893.2

OPEN WOUND OF TOE(S) WITHOUT COMPLICATION - OPEN WOUND OF TOE(S) WITH TENDON INVOLVEMENT

923.3

CONTUSION OF FINGER

924.3

CONTUSION OF TOE

927.3

CRUSHING INJURY OF FINGER(S)

928.3

CRUSHING INJURY OF TOE(S)

945.31

FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF TOE(S) (NAIL)

945.51

DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF TOE(S) (NAIL) WITH LOSS OF TOE(S)

Diagnoses that Support Medical Necessity

Conditions that are listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity

All those not listed under the “ICD-9 Codes that Support Medical Necessity” section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Conditions that are not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

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Other Information

Documentation Requirements

All documentation must be maintained in the patient’s medical record and available to the contractor upon request.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.

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.

Surgical treatment of toenails, 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", etc.).

It is inappropriate to state "no anesthesia used due to a possible anesthetic reaction" without indicating the patient's allergies in the medical record.

For procedure codes 11730, 11732, 11750, 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 see article A47803, 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 more often than every 12 weeks are considered to be not medically reasonable and necessary.

Sources of Information and Basis for Decision

Other Contractor's Policies

Novitas Solutions Contractor Medical Directors

Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Directors. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the appropriate specialty (ies).

CAC/IAC Distribution: 04/01/2008

Start Date of Comment Period

04/01/2008

End Date of Comment Period:

05/15/2008

Start Date of Notice Period

05/23/2008

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Revision History

Revision History Number

L27532

Revision History Explanation

Date Policy # Description

04/02/2012

L27532

LCD revised to reflect contractor name change from Highmark Medicare Services to Novitas Solutions, Inc.

02/21/2011

L27532

Per Change Request 7135, this LCD is effective for dates of service on and after 02/21/2011 for those providers in the states of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia serviced by Wisconsin Physicians Service (WPS), contractor number 52280, that are being transitioned to Highmark Medicare Services, contractor number 12901, effective 02/21/2011.

09/08/2010

L27532

LCD revised effective 09/09/2010. The descriptions have changed for the following bill type codes: 11, 12, 13, 14, 18, 21, 22, 23, 28, 83, and 85 with an effective date of 07/01/2010. The descriptions have changed for the following revenue codes: 0310, 0311, 0312, 0314, 0319, 0360, 0361, 0362, 0367, 0369, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0760, 0761, 0762, and 0769 with an effective date of 07/01/2010. Some or all of these changes may be in code ranges.

10/08/2009

L27532

LCD revision effective 10/09/2009. For clarification, revenue code 020X removed and revenue code 076X added.

12/12/2008

L27532

LCD effective 12/12/2008 for Pennsylvania Part B. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Part B; Maryland Part A and Part B; New Jersey Part A and Part B; Pennsylvania Part A and Part B.

11/14/2008

L27532

LCD effective 11/14/2008 for New Jersey Part B and Delaware Part A. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Delaware Part B; Maryland Part A and Maryland Part B; New Jersey Part A and New Jersey Part B; Pennsylvania Part A.

10/16/2008

L27532

Typographical error corrected. ICD-9-CM Code corrected from 110.0 to 110.1.

08/29/2008

L27532

LCD effective 09/01/2008 for New Jersey Part A. Effective 09/01/2008, New Jersey Part A will be added to the other jurisdictions already effective: DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

08/01/2008

L27532

LCD effective 08/01/2008 for DC Part A, Maryland Part A, and Pennsylvania Part A. LCD is now effective for DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

05/23/2008

L27532

Original LCD posted for notice. LCD to become effective 07/11/2008 for Maryland Part B, DCMA Part B and Delaware Part B.

04/01/2008

Draft J12-D46

Original LCD posted for comment.

Reason for Change

Other

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.