Anthem

Clinical UM Guideline

Subject: Surgical Treatment for Dupuytren's Contracture
Guideline #: CG-SURG-11
Status: Revised

Publish Date: 06/28/2023
Last Review Date: 05/11/2023

Description

This document addresses surgical treatments for Dupuytren's contracture. Dupuytren's contracture is a painless thickening and fixed tightening (contracture) of the tissue beneath the skin on the palm of the hand and fingers. Progressive contracture may result in deformity and loss of function of the hand.

Clinical Indications

Medically Necessary:

Surgical treatment for Dupuytren's contracture is considered **medically necessary** when a palpable palmar cord has been documented to impair the individual's functional activities **and** any of the following:

A. Contracture at the proximal interphalangeal (PIP) joint or distal interphalangeal (DIP) joint of 20 degrees or more; **or**
B. Contracture at the metacarpophalangeal (MP) joint of 20 degrees or more; **or**
C. Symptomatic Dupuytren's contracture (that is, pain, tenderness, or functional impairment).

Not Medically Necessary:

Surgical treatment for Dupuytren's contracture is considered **not medically necessary** when the criteria above are not met.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
26040	Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous
26045	Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial

ICD-10 Procedure	
0MN70ZZ	Release right hand bursa and ligament, open approach
0MN73ZZ	Release right hand bursa and ligament, percutaneous approach
0MN74ZZ	Release right hand bursa and ligament, percutaneous endoscopic approach
0MN80ZZ	Release left hand bursa and ligament, open approach
0MN83ZZ	Release left hand bursa and ligament, percutaneous approach
0MN84ZZ	Release left hand bursa and ligament, percutaneous endoscopic approach

ICD-10 Diagnosis	
M72.0	Contracture of palmar fascia

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met.

Discussion/General Information

Dupuytren's contracture is a multifactorial disease, meaning that several causes have been associated with the development of the disease, but a single cause is not known. The disease is most common in Caucasian males over 50 years of age. It has also been shown to be more common in those with diabetes, seizure disorders, human immunodeficiency virus (HIV) positive status, hypothyroidism, those who smoke and those who consume alcohol. Minor trauma and genetic predisposition may play a role. One or both hands may be affected. The ring finger is affected most often, followed by the little, middle, and index fingers. The metacarpophalangeal (MCP) and proximal interphalangeal (PIP) joints are the most commonly affected joints.

Initially, a small, painless nodule develops in the connective tissue and eventually develops into a cord-like band. The cord tightens over time, and may progress rapidly and become symptomatic by pulling the affected finger towards the palm in an abnormal position or contracture. Extension of the finger becomes difficult to impossible with advanced cases. The goal of surgery (palmar fasciectomy) is to release or excise the fibrous attachments between the palmar fascia and the tissues around it, thereby releasing the contracture. Once released, finger movement should improve; although this is largely dependent upon the joint(s) being treated. Surgery is more effective if the contracture occurs in the MCP joint of only one finger and is less effective when two or more fingers and MCP joints are involved. When the contracture occurs at the PIP joint, the improvement rate decreases (Bird, 2007).

In 2012, van Rijssen and colleagues reported 5-year results of a clinical trial comparing percutaneous needle fasciotomy versus limited fasciectomy for the treatment of Dupuytren's contracture. A total of 111 subjects with a minimal passive extension deficit of 30 degrees were randomized into one of two groups. The primary endpoint was recurrence and a total of 93 subjects reached the endpoint. The recurrence after 5 years was greater in the needle fasciotomy group than in the limited fasciectomy group (84.9% vs. 20.9% respectively) and occurred sooner in the needle fasciotomy group (p=0.0001). Individual satisfaction was higher in the limited fasciectomy group; however, 53% of the subjects preferred percutaneous needle fasciotomy in case of recurrence.

A 2015 Cochrane review noted that participant satisfaction was better after fasciotomy at 6 weeks, but the magnitude of effect was not specified. Fasciectomy improved contractures more effectively in severe disease. Mean percentage reduction in total passive extension deficit at 6 weeks for Tubiana grades I and II was 11% lower after needle fasciotomy than after fasciectomy, whereas for grades III and IV disease, it was 29% and 32% lower. By 5 years, satisfaction (on a scale from 0 to 10, with higher scores showing greater satisfaction) was 2.1/10 points higher in the fasciectomy group than in the fasciotomy group, and recurrence was greater after fasciotomy (849/1000 vs 209/1000). The authors concluded that the evidence is insufficient to show the relative superiority of different surgical procedures for treating Dupuytren's contracture and that well designed studies are needed (Rodrigues, 2015).

References

Peer Reviewed Publications:

1. Chen NC, Srinivasan RC, Shauver MJ, et al. A systematic review of outcomes of fasciotomy, aponeurotomy, and collagenase treatments for Dupuytren's contracture. Hand (N Y). 2011; 6(3):250-255.
2. Crean SM, Gerber RA, Le Graverand MP, et al. The efficacy and safety of fasciectomy and fasciotomy for Dupuytren's contracture in European patients: a structured review of published studies. J Hand Surg Eur. 2011; 36(5):396-407.
3. Dias JJ, Braybrooke J. Dupuytren's contracture: an audit of the outcomes of surgery. J Hand Surg Br. 2006; 31(5):514-521.
4. Foucher G, Medina J, Navarro R. Percutaneous needle aponeurotomy: complications and results. J Hand Surg Br. 2003; 28(5):427-431.
5. Hovius SE, Kan HJ, Smit X, et al. Extensive percutaneous aponeurotomy and lipografting: a new treatment for Dupuytren disease. Plast Reconstr Surg. 2011;128(1):221-228.
6. Kan HJ, Selles RW, van Nieuwenhoven CA, et al. Percutaneous aponeurotomy and lipofilling (PALF) versus limited fasciectomy in patients with primary Dupuytren's contracture: A prospective, randomized, controlled trial. Plast Reconstr Surg. 2016; 137(6):1800-1812.
7. Lee LC, Zhang AY, Chong AK, et al. Expression of a novel gene, MafB, in Dupuytren's disease. J Hand Surg Am. 2006; 31(2):211-218.
8. Naam NH. Functional outcome of collagenase injections compared with fasciectomy in treatment of Dupuytren's contracture. Hand (N Y). 2013; 8(4):410-416.
9. Peimer CA, Wilbrand S, Gerber RA, et al. Safety and tolerability of collagenase Clostridium histolyticum and fasciectomy for Dupuytren's contracture. J Hand Surg Eur. 2015; 40(2):141-149.
10. Selles RW, Zhou C, Kan HJ, et al. Percutaneous aponeurotomy and lipofilling versus limited fasciectomy for Dupuytren's contracture: 5-Year results from a randomized clinical trial. Plast Reconstr Surg. 2018; 142(6):1523-1531.
11. van Rijssen AL, Linden H, Werker PM. Five-year results of a randomized clinical trial on treatment in Dupuytren's disease: percutaneous needle fasciotomy versus limited fasciectomy. Plast Reconstr Surg. 2012; 129(2):469-477.
12. Zhou C, Hovius SE, Slijper HP, et al. Collagenase Clostridium histolyticum versus limited fasciectomy for dupuytren's contracture: outcomes from a multicenter propensity score matched study. Plast Reconstr Surg. 2015; 136(1):87-97.

Government Agency, Medical Society, and Other Authoritative Publications:

1. Brazzelli M, Cruickshank M, Tassie E, et al. Collagenase clostridium histolyticum for the treatment of Dupuytren's contracture: systematic review and economic evaluation. Health Technol Assess. 2015; 19(90):1-202.
2. Rodrigues JN, Becker GW, Ball C, et al. Surgery for Dupuytren's contracture of the fingers. Cochrane Database Syst Rev. 2015; (12):CD010143.

Websites for Additional Information

1. American Academy of Orthopedic Surgeons (AAOS). Dupuytren's Disease. Available at: https://orthoinfo.aaos.org/en/diseases--conditions/dupuytrens-disease/. Accessed on March 21, 2023.
2. Dupuytren Foundation. Available at: https://dupuytrens.org/. Accessed on March 21, 2023.

Index

The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

History

Status	Date	Action
Revised	05/11/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Reformatted bullets to alphanumeric in Clinical Indications section. Updated Websites for Additional Information section.
Reviewed	05/12/2022	MPTAC review. Updated Websites for Additional Information section.
Reviewed	05/13/2021	MPTAC review. Discussion/General Information, References, and Websites for Additional Information sections updated. Reformatted Coding section.
Reviewed	05/14/2020	MPTAC review. References were updated.
Revised	06/06/2019	MPTAC review. The MN criteria for surgery were revised to clarify symptomatic contracture. Updated References section.
Reviewed	07/26/2018	MPTAC review. Updated References section.
	05/03/2018	The document header wording updated from "Current Effective Date" to "Publish Date."
Reviewed	08/03/2017	MPTAC review. Updated References section.
Reviewed	08/04/2016	MPTAC review. Discussion, References and Websites were updated. Updated formatting in Clinical Indications section. Removed ICD-9 codes from Coding section.
Reviewed	08/06/2015	MPTAC review. References were updated.
Reviewed	08/14/2014	MPTAC review. References were updated.
Reviewed	08/08/2013	MPTAC review. References were updated.
Reviewed	08/09/2012	MPTAC review. Discussion/General Information and References updated.

Revised	08/18/2011	MPTAC review. Medically necessary contracture criteria for the metacarpophalangeal (MP) joint changed to 20 degrees. Discussion/General Information and References updated.
Revised	11/18/2010	MPTAC review. Criteria revised to include contracture measurements. Title changed. Discussion/General Information and References were updated.
Reviewed	11/19/2009	MPTAC review. Place of service removed. Discussion and references were updated.
Reviewed	11/20/2008	MPTAC review. References were updated.
Reviewed	11/29/2007	MPTAC review. References were updated.
Reviewed	12/07/2006	MPTAC review. References updated.
Revised	12/01/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.			None
WellPoint Health Networks, Inc.	12/02/2004	Guideline	Dupuytren's Contracture Release

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.