MEDICAL POLICY

POLICY TITLE	DRY NEEDLING OF TRIGGER POINTS FOR MYOFASCIAL PAIN
POLICY NUMBER	MP 4.041

Effective Date:	7/1/2023

I. POLICY

Dry needling of trigger points for the treatment of myofascial pain is considered **investigational** as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Cross-reference:
MP 2.072 Trigger Point and Tender Point Injections

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

III. DESCRIPTION/BACKGROUND

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Myofascial Trigger Points

Myofascial pain is defined by the presence of trigger points: Discrete, focal, hyperirritable spots within a taut band of skeletal muscle fibers that produce local and/or referred pain when stimulated. Trigger points are associated with local ischemia and hypoxia, a significantly lowered pH, local and referred pain, and altered muscle activation patterns. Trigger points can be visualized by magnetic resonance imaging and elastography. The reliability of manual identification of trigger points has not been established.

Dry Needling

Dry needling refers to a procedure in which a fine needle is inserted into the skin and muscle at a site of myofascial pain. The needle may be moved in an up-and-down motion, rotated, and/or left in place for as long as 30 minutes. The intent is to stimulate underlying myofascial trigger points, muscles, and connective tissues to manage myofascial pain. Dry needling may be performed with acupuncture needles or standard hypodermic needles but is performed without the injection of medications (eg, anesthetics, corticosteroids). Dry needling is proposed to treat

dysfunctions in skeletal muscle, fascia, and connective tissue; diminish persistent peripheral pain; and reduce impairments of body structure and function.

The physiologic basis for dry needling depends on the targeted tissue and treatment objectives. The most studied targets are trigger points.

Deep dry needling is believed to inactivate trigger points by eliciting contraction and subsequent relaxation of the taut band via a spinal cord reflex. This local twitch response is defined as a transient visible or palpable contraction or dimpling of the muscle, and has been associated with alleviation of spontaneous electrical activity; reduction of numerous nociceptive, inflammatory, and immune system-related chemicals; and relaxation of the taut band. Deep dry needling of trigger points is believed to reduce local and referred pain, improve range of motion, and decrease trigger point irritability.

Superficial dry needling is thought to activate mechanoreceptors and have an indirect effect on pain by inhibiting C-fiber pain impulses. The physiologic basis for dry needling treatment of excessive muscle tension, scar tissue, fascia, and connective tissues is not as well described in the literature.

REGULATORY STATUS

Dry needling is considered a procedure and, as such, is not subject to regulation by FDA.

IV. RATIONALE

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SUMMARY OF EVIDENCE

For individuals who have myofascial trigger points associated with neck and/or shoulder pain who receive dry needling of trigger points, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. A systematic review of techniques to treat myofascial pain included 15 studies of dry needling for neck or shoulder pain published through 2017. Studies had multiple methodological limitations, and the reviewers concluded that the evidence for dry needling was not greater than placebo. In more recent systematic reviews and meta-analyses, dry needling was not associated with clinically important reductions in shoulder or neck pain when compared to other physical therapy modalities. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have myofascial trigger points associated with plantar heel pain who receive dry needling of trigger points, the evidence includes RCTs, quasi-experimental studies, and a systematic review. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The systematic review, which included 3 quasi-experimental studies, rated study quality as poor. One RCT was double-blind and sham-controlled; it found a statistically significant greater reduction in pain in the dry needling group than in the sham group but the difference was not clinically significant (i.e., it did not meet the prespecified minimally

important difference). The other RCT, a single-blind trial comparing dry needling with usual care, found a significantly greater reduction in pain at the end of active treatment but not at follow-up one month later. Moreover, range of motion outcomes did not differ significantly between groups at either time point. To date, the studies have not demonstrated a statistical or a clinical benefit for dry needling. Additional RCTs, especially those with a sham-control group, would strengthen the evidence base. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have myofascial trigger points associated with temporomandibular myofascial pain who receive dry needling of trigger points, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. One double-blind, sham-controlled randomized trial was identified; it found that one week after completing the intervention, there were no statistically significant differences between groups in pain scores or function (unassisted jaw opening without pain). There was a significantly higher pain pressure threshold in the treatment group. Additional RCTs, especially those with a sham-control group, are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

V. DEFINITIONS

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N/A

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice, and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered dry needling of trigger points:

Procedure Codes								
20560	20561	20999						

IX. REFERENCES

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1. *American Physical Therapy Association (APTA). Dry Needling. n.d.*
2. *Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. Am Fam Physician. Feb 15 2002; 65(4): 653-60. PMID 11871683*
3. *Charles D, Hudgins T, MacNaughton J, et al. A systematic review of manual therapy techniques, dry cupping and dry needling in the reduction of myofascial pain and myofascial trigger points. J Bodyw Mov Ther. Jul 2019; 23(3): 539-546. PMID 31563367*
4. *Navarro-Santana MJ, Sanchez-Infante J, Fernandez-de-Las-Penas C, et al. Effectiveness of Dry Needling for Myofascial Trigger Points Associated with Neck Pain Symptoms: An Updated Systematic Review and Meta-Analysis. J Clin Med. Oct 14 2020; 9(10). PMID 33066556*
5. *Navarro-Santana MJ, Gomez-Chiguano GF, Cleland JA, et al. Effects of Trigger Point Dry Needling for Nontraumatic Shoulder Pain of Musculoskeletal Origin: A Systematic Review and Meta-Analysis. Phys Ther. Feb 04 2021; 101(2). PMID 33340405*
6. *Cotchett MP, Landorf KB, Munteanu SE. Effectiveness of dry needling and injections of myofascial trigger points associated with plantar heel pain: a systematic review. J Foot Ankle Res. Sep 01 2010; 3: 18. PMID 20807448*
7. *Cotchett MP, Munteanu SE, Landorf KB. Effectiveness of trigger point dry needling for plantar heel pain: a randomized controlled trial. Phys Ther. Aug 2014; 94(8): 1083-94. PMID 24700136*
8. *Eftekharsadat B, Babaei-Ghazani A, Zeinolabedinzadeh V. Dry needling in patients with chronic heel pain due to plantar fasciitis: A single-blinded randomized clinical trial. Med J Islam Repub Iran. 2016; 30: 401. PMID 27683642*
9. *Diracoglu D, Vural M, Karan A, et al. Effectiveness of dry needling for the treatment of temporomandibular myofascial pain: a double-blind, randomized, placebo controlled study. J Back Musculoskelet Rehabil. 2012; 25(4): 285-90. PMID 23220812*
10. *Brady S, McEvoy J, Dommerholt J, et al. Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists. J Man Manip Ther. Aug 2014; 22(3): 134-40. PMID 25125935*
11. *American Academy of Orthopaedic Physical Therapists. AAOMPT position statement on dry needling. 2009*
12. *American Physical Therapy Association (APTA). Physical Therapists and the Performance of Dry Needling. 2012*

13. Blue Cross Blue Shield Association Medical Policy Reference Manual. 2.01.100, Dry Needling of Myofascial Trigger Points. May 2022

X. POLICY HISTORY

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MP-4.041	**CAC 01/31/2017 New policy**. BCBSA adopted. Dry needling of trigger points for the treatment of myofascial pain is considered investigational. Coding reviewed.
	12/19/2017 Consensus review. Policy statement unchanged. Description/Background, Rationale, and Reference sections updated.
	09/17/2018 Consensus review. No change to the policy statement. Background and rationale revised. References reviewed.
	07/30/2019 Consensus Review. Policy statement unchanged. References updated.
	01/01/2020 Coding update. New codes 20560 and 20561 added.
	06/24/2020 Consensus Review. No change to policy statement. Policy name updated to Dry Needling of Trigger Points For Myofacial Pain.
	05/13/2021 Consensus review. No change to policy statement. Background, Rationale, and reference updated. Coding reviewed.
	05/19/2022 Consensus review. No change to policy statement. References reviewed and updated.
	3/24/2023 Consensus review. No change to policy statement. References reviewed.

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