MEDICAL POLICY

POLICY TITLE	TRIGGER POINT AND TENDER POINT INJECTIONS
POLICY NUMBER	MP-2.072

Effective Date:	12/1/2023

I. POLICY

Trigger point injections with anesthetic and/or corticosteroid may be considered **medically necessary** for the treatment of chronic neck or back pain or myofascial pain syndrome when all of the following criteria have been met:

- There is a regional pain complaint in the expected distribution of referral pain from a trigger point, **AND**
- There is spot tenderness in a palpable taut band in a muscle, **AND**
- There is restricted range of motion, **AND**
- Conservative therapy (e.g., physical therapy, active exercises, ultrasound, heating or cooling, massage, activity modification, or pharmacotherapy) for 6 weeks fails or is not feasible, **AND**
- Trigger point injections are provided as a component of a comprehensive therapy program, **AND**
- No more than 4 injections total are given in a rolling 12-month period

Trigger point and tender point injections are considered **investigational** for all other indications not meeting the criteria above. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Ultrasound and other imaging guidance of trigger point injections 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 3.015 Office Based Procedures Performed in a Facility
MP 4.014 Epidural Steroid Injections for Back Pain and Facet Nerve Blocks
MP 4.041 Dry Needling of Myofascial Trigger Points
MP 8.012 Neural Therapy

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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Trigger points are discrete, focal, hyperirritable spots within a taut band of skeletal muscle fibers that produce local and/or referred pain when stimulated. Tender points also produce local pain when stimulated but lack the taut band of tissue and hyperirritability when palpated. Injection of an anesthetic agent or botulinum toxin into trigger points and tender points is being evaluated for the management of a variety of pain syndromes.

Trigger Points

Trigger points are 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.

Treatment

Trigger point injections with local anesthetic, saline, steroid, or botulinum toxin type A are a potential treatment for pain associated with trigger points. Alternative nonpharmacologic treatment modalities for trigger point pain include manual techniques, massage, acupressure, ultrasonography, application of heat or ice, diathermy, transcutaneous electrical nerve stimulation, and spray cooling with manual stretch.

Associated Disorders

Myofascial Pain Syndrome

Myofascial pain syndrome is a chronic regional pain disorder caused by the activation of at least 1 trigger point in muscles, tendons, or muscle fascia. It can cause local or referred pain, tightness, tenderness, stiffness and limitation of movement, muscle weakness, and often autonomic phenomena. The severity of symptoms and degree of functional impairment vary. Some individuals will have few trigger points with mild symptoms and no functional impairment, while others will have multiple satellite trigger points, widespread and severe pain, and major functional impairments. Conditions that can lead to myofascial pain syndrome include chronic repetitive minor muscle strain, poor posture, systemic disease, strain, sprain, enthesopathy, and arthritis. Management of chronic myofascial pain typically includes behavioral and pharmacologic approaches and physical therapy. Injection of a local anesthetic or botulinum toxin has also been reported.

Complex Regional Pain Syndrome

Complex regional pain syndrome (previously called sympathetic dystrophy) refers to a chronic and disabling condition characterized by persistent pain that is disproportionate to the extent and duration of the primary injury and that is not restricted to the distribution of a specific peripheral nerve. Complex regional pain syndrome occurs most commonly following wrist fracture, but may

follow many other types of injury, even when the preceding injury is relatively minor. Complex regional pain syndrome may also occur when there is no known injury. Complex regional pain syndrome is classified into type I when a specific nerve lesion has not been identified and type II when there is an identifiable nerve lesion. The pain may consist of thermal or mechanical allodynia (pain that occurs from a stimulus that normally does not elicit a painful response such as light touch or warmth) dysesthesia (a constant or ongoing unpleasant or electrical sensation of pain), and/or hyperalgesia (an exaggerated response to normally painful stimuli). Management of complex regional pain syndrome includes oral and topical pharmacotherapy, physical therapy, psychological therapies, and interventional procedures such as regional anesthetic blocks, sympathetic blocks, or spinal cord stimulation. Amputation of the affected limb has also been performed.

Abdominal Wall Pain

A source of chronic abdominal wall pain is anterior cutaneous nerve entrapment syndrome, which typically presents as sharp and focal abdominal pain, and is often found near a scar. One hypothesis is that anterior cutaneous nerve entrapment syndrome results from the entrapment and ischemia of an anterior cutaneous branch of a thoracic nerve as it passes through the rectus abdominus muscle. Anterior wall pain can be distinguished from intra-abdominal pain by documenting that pain increases with maneuvers that tense the abdominal muscles. It has also been proposed that abdominal wall pain may be due to a myofascial trigger point in the rectus abdominus muscle.

Tender Points

Tender points are focal areas of hyperalgesia that tend to occur at muscle-tendon junctions. Tender points are differentiated from trigger points due to the absence of a taut band of muscle tissue or local hyperirritability (“jump response”) when palpated.

Despite the lack of local hyperirritability or a palpable band of tissue, some practitioners have treated tender points with injections of local anesthetic, corticosteroids, or botulinum toxin, similar to the treatment of trigger points.

Associated Disorders

Fibromyalgia

Fibromyalgia is a chronic condition characterized by widespread pain with hyperalgesia and allodynia. Constitutional symptoms such as fatigue, impaired cognition, and disrupted sleep can also occur. Early diagnostic criteria for fibromyalgia (1990) included three or more months of widespread pain above and below the waist, on both sides of the body, and along the midline, with at least 11 of 18 specific tender points. The defined bilateral areas from the American College of Rheumatology criteria are occipital, low cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, and knee medial fat pad. However, 2010 diagnostic criteria from the College, which were designed to facilitate diagnosis in a general practice setting, did not include a tender point exam but instead relied on the presence of widespread pain and other symptoms.

REGULATORY STATUS

Although medications used with invasive trigger point and tender point procedures are regulated by the U.S. Food and Drug Administration (FDA), trigger and tender point injections are procedures and, as such, are not subject to regulation by the FDA.

IV. RATIONALE

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Summary of Evidence

For individuals who have myofascial pain syndrome who receive trigger point injections, the evidence includes several randomized controlled trials (RCTs) and a systematic review of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Lidocaine injections have been compared with physical therapy, lidocaine patches, sham stimulation, and dry needling. Some trials have reported that injecting lidocaine into trigger points improve subjective pain ratings to the same degree as physical therapy or lidocaine patches, but only slightly more than sham stimulation. Other trials have found that lidocaine injection was superior to dry needling on subjective pain ratings, but there was no significant benefit with lidocaine injection assessed on objective outcome measures. These results suggest a strong placebo effect of the treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have complex regional pain syndrome who receive trigger point injections, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Evidence on treatment of complex regional pain syndrome with trigger point injections is very limited, with only case series published and no recent literature identified for this treatment approach. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have abdominal wall pain who receive trigger point injections, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The single RCT evaluated lidocaine injections in women who had chronic pelvic pain and abdominal wall trigger points. Additional study in a larger population is needed to permit greater certainty about the efficacy of this treatment approach. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have fibromyalgia who receive tender point injections, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The single RCT identified evaluated the efficacy of lidocaine injections in patients with fibromyalgia. It found a strong placebo effect, with lidocaine injection being not more effective than saline at reducing fibromyalgia pain. 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.

Ultrasound and other imaging guidance of trigger point injections is considered investigational; therefore, not covered:

Procedure Codes								
76942	77002	77012	77021					

A maximum of four (4) injections (total) within a rolling 12-month period are covered when medically necessary:

Procedure Codes								
20552	20553							

ICD-10-CM Diagnosis Code	Description
G89.29	Other Chronic Syndrome
G89.4	Chronic Pain Syndrome
M54.2	Cervicalgia

ICD-10-CM Diagnosis Code	Description
M54.5	Low Back Pain
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M79.10	Myalgia, unspecified site
M79.12	Myalgia of auxiliary muscles, head, and neck
M79.18	Myalgia, other site

IX. REFERENCES

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X. POLICY HISTORY

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MP 2.072	**CAC 1/31/17** Policy criteria were previously addressed in MP-4.014 Pain Control. BCBSA policy adopted. Trigger and tender point injections are considered medically necessary for myofascial pain under specified conditions. Coding added.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies.
	1/12/18 Minor review. Policy statement updated to state that imaging in addition to ultrasound is considered investigational. Coding reviewed
	10/1/18 Admin Update: Removed deleted ICD-10 codes. Added new ICD-10 codes effective 10/1/18

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	10/17/18 Consensus review. No change to policy statements. References updated. Rationale condensed.
	5/24/19 Minor review. Added chronic neck and back pain as well as fibromyalgia as medically necessary indications. Updated references and coding.
	4/29/2020: Consensus Review. No change to policy statement. References checked and updated. Coding reviewed with no changes.
	9/7/2021: Administrative review. Addition of new ICD-10 codes. Effective date 10/1/2021.
	12/8/2021 Minor review. Removed fibromyalgia as a medically necessary indication. FEP statement updated. Rationale and coding updated. References updated.
	07/07/2022 Minor review. Tender Point injections changed from medically necessary to investigational. Added code 77012 as not covered. Background, Rationale and References updated.
	06/07/2023 Minor review. Added "rolling" to the 12-month time period. Also added that it is 4 injections total. Background and References updated.

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