02-20000-28

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Subject: Trigger Point Injections

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement | Billing/Coding | Reimbursement | Program Exceptions | Definitions | Related Guidelines

Other | References | Updates

DESCRIPTION:

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 activationpatterns.

Summary and Analysis of Evidence: An RCT by Lugo et al (2016) evaluated the efficacy of lidocaine injection into trigger points and PT to treat myofascial pain syndrome. Strengths of this trial included the randomization procedures, power analysis, and assessor blinding. Patients (N=127) with shoulder girdle myofascial pain syndrome for at least 6 weeks and visual analog scale scores for pain greater than 40 mm received PT, a single injection of lidocaine, or both treatments together. The primary outcome (visual analog scale pain rating at 1 month) did not differ significantly across the 3 groups (lidocaine, 44.2; PT, 37.8; combined therapy, 40.8). Most secondary outcome measures (function, depression, quality of life) were also similar across groups. Brennan et al (2017) reported on a partially blinded, noninferiority RCT comparing corticosteroid injections into trigger points (n=25 hips) with dry needling (n=25 hips) for patients who had greater trochanteric pain syndrome (previously called greater trochanteric bursitis), a chronic, intermittent pain syndrome involving tenderness over the lateral hip. The trial was powered with a planned enrollment of 50 patients, using a 2-sample t test for noninferiority and a noninferiority margin of 1.5. Patients were randomized to a corticosteroid injection or to a dry injection by an orthopedic surgeon or a physician assistant and followed at the provider's discretion over 6 weeks. At 6 weeks, numeric rating scale scores for pain did not differ significantly between groups (difference, -1.12; 95% confidence interval, -2.99 to 0.74). Similarly, there were no significant differences in functional outcomes or medication use. An RCT by Affaitati et al (2009) compared use of a lidocaine infiltration into trigger points, lidocaine patch, or placebo patch in 60 patients being treated for myofascial pain syndrome. Strengths of this trial included allocation concealment for the lidocaine and placebo patches, blinded evaluation, and sample size calculations for

adequate power. Similar reductions in pain and pain thresholds with the 2 lidocaine treatments were reported but significantly less discomfort was associated with the lidocaine patch than with injection. With the lidocaine patch, pain decreased from 84.0 to 17.25; with lidocaine injection, pain decreased from 79.95 to 14.30. With the placebo patch, pain on movement remained unchanged (78.35 at baseline vs. 77.50 on day 9).

Ultrasound and other imaging methods have been investigated to identify the trigger point and to visualize the twitch response resulting from trigger point injection. The evidence in the published clinical literature evaluating the efficacy of using ultrasound or other guidance to administer trigger point injections consists mostly of case reports, pilot studies, and literature reviews. UpToDate review "Myofascial pelvic pain syndrome in females: Treatment" (Barker, Elkadry; 2024) states, "Clinically, patients are often able to indicate which areas of the muscles are most painful and therefore require injection. Although some clinicians use electromyography or ultrasound to locate trigger points, these modalities do not appear to improve the efficacy of TPIs in studies of nonpelvic trigger points. Further studies are needed to determine if imaging or other modalities provide superior accuracy for TPIs." Cojocaru et al (2015) conducted a pilot study of 8 participants, to examine whether there is a correlation between the clinical findings of muscle pain in the low back, ultrasound examination and thermal pattern of trigger points by infrared thermography. An ultrasound examination was performed to evaluate the trigger point dimensions. The ultrasound showed an ellipsoidal hypoechogenic area in the muscle. A thermography of the low back region was also performed in order to observe the thermal pattern of the area. The authors concluded "(i)nfrared thermography could be a great asset for the monitoring of neuromusculoskeletal disorders and their dynamics, as well as an important aid for the initial diagnosis of conditions associated with tissue temperature alterations." This study was limited by its small size, and lack of control group and control sites. Srbely et al (2016) examined the use of myofascial trigger points (MTrP) for treatment of chronic musculoskeletal pain, including myofascial pain syndrome (MPS). The authors state, "(t)he most commonly employed clinical technique used to confirm the presence of a MTrP is manual palpation. Despite this, the sensitivity and/or specificity of manual palpation for detecting MTrP has not been studied because there is presently no known "gold" standard measure for a MTrP locus. Given the variation in the clinical presentation of chronic musculoskeletal pain and the challenges in reliably detecting MTrP, chronic musculoskeletal pain is inconsistently diagnosed. Although not routinely employed in the clinical assessment of MTrP, the accumulating body of research suggests that diagnostic ultrasound may have the potential to significantly contribute to the identification of MTrP within skeletal muscle. Its sensitivity and specificity for detecting palpable nodules has not yet been studied. Future research should aim to establish the association between manual palpation and sonographic findings in order to validate these techniques for future clinical application."

Garcia-de-la-Banda-Garcia et al (2023) conducted an RCT that compared dry needling to manual therapy in 50 individuals with temporomandibular disorders. Participants and physical therapists were unblinded, and each patient received 3 sessions, each 4 days apart. Patients were followed until 2 weeks after the last treatment. Both groups experienced improvements from baseline to the end of the study but there was no difference between groups in pain intensity, maximal mouth opening, or disability (using the Neck Disability Index). The study may have lacked a sufficient number of participants to detect differences between groups; a power/sample size calculation was not reported. Charles et al (2019) conducted a systematic review of different techniques for treatment of myofascial pain. A total of 23 RCTs of dry needling were included. Of these, 15 assessed the technique for neck or shoulder pain.

The quality of evidence for dry needling in the management of myofascial pain and trigger points ranged from very low to moderate compared with control groups, sham interventions, or other treatments for changes in pain, pressure point threshold, and functional outcomes. Multiple limitations in the body of the evidence were identified, including high risk of bias, small sample sizes, unclear randomization and concealment procedures, inappropriate blinding, imbalanced baseline characteristics, lack of standardized methodologies, unreliable outcome measures, high attrition rates, unknown long-term treatment effects, lack of effective sham methods, and lack of standardized guidelines in the location of trigger points. The reviewers concluded that the evidence for dry needling was not greater than placebo. Para-Garcia et al (2022) conducted a systematic review and meta-analysis of dry-needling compared with other interventions in patients with subacromial pain syndrome. Five RCTs (N=315) published between 2012 and 2022 were included. The intervention group included 3 studies with dry needling in combination with exercise and 2 studies with dry needling alone while the control group had a wide range of interventions including exercise, stretching, massage, heat, and electrotherapy. Dry needling was generally performed for 2 sessions over 3 or 4 weeks, but 1 study had all sessions in 1 week. Minimal information was available on session duration. Short-term pain was reduced with dry needling either alone or when combined with exercise compared with other interventions (low quality evidence), but the difference between groups was small and clinical relevance is questionable. Pain intensity was also reduced at mid-term (1 to 12 months) based on low-quality evidence; however, there was no difference in disability between groups. The quality of evidence was low to very-low due to lack of blinding and imprecision.

POSITION STATEMENT:

Trigger point injections (20552, 20553) meet the definition of medical necessity to treat trigger points when **ALL** of the following criteria are 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, activity modification, pharmacotherapy) for 6 weeks fails or is not feasible
- Injections do not exceed 4 in 30 days or 6 in 6 months, per anatomic location

Imaging guidance (ultrasound or fluoroscopic) performed with **trigger point injection (20552, 20553)** is considered **experimental or investigational**, as there is insufficient clinical evidence to permit scientific conclusions on net health outcomes.

Dry-needling of trigger points (20560, 20561) is considered **experimental or investigational**, as there is insufficient clinical evidence to permit scientific conclusions on net health outcomes.

BILLING/CODING INFORMATION:

CPT Coding:

20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s) **(investigational)**
20561	Needle insertion(s) without injection(s); 3 or more muscles **(investigational)**

ICD-10 Diagnosis Codes That Support Medical Necessity for 20552 – 20553:

C49.9	Malignant neoplasm of connective and soft tissue, unspecified
M25.721 – M25.729	Osteophyte, elbow
M25.751 – M25.759	Osteophyte, hip
M25.771 – M25.776	Osteophyte, ankle or foot
M35.4	Diffuse (eosinophilic) fasciitis
M46.00 – M46.09	Spinal enthesopathy
M53.82	Other specified dorsopathies, cervical region
M53.9	Dorsopathy, unspecified
M54.00 – M54.09	Panniculitis affecting regions of neck and back,
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M60.10	Interstitial myositis of unspecified site
M60.111 – M60.179	Interstitial myositis
M60.80 – M60.9	Other myositis
M60.9	Myositis, unspecified
M62.4	Contracture of muscle, unspecified site
M62.411 – M62.49	Contracture of muscle
M62.830 – M62.838	Muscle spasm
M62.89	Other specified disorders of muscle
M65.30	Trigger finger, unspecified finger
M65.311 – M65.359	Trigger finger
M65.4	Radial styloid tenosynovitis [de Quervain]
M65.80	Other synovitis and tenosynovitis, unspecified site
M65.811 – M65.9	Other synovitis and tenosynovitis
M65.841 – M65.849	Other synovitis and tenosynovitis, hand
M65.871 – M65.879	Other synovitis and tenosynovitis, ankle and foot
M65.88	Other synovitis and tenosynovitis, other site
M65.89	Other synovitis and tenosynovitis, multiple sites
M65.9	Synovitis and tenosynovitis, unspecified
M67.30 – M67.39	Transient synovitis
M70.20 – M70.22	Olecranon bursitis, elbow
M70.30 – M70.32	Other bursitis of elbow
M70.60 – M70.62	Trochanteric bursitis, hip

M70.70 – M70.72	Other bursitis of hip
M71.30	Other bursal cyst, unspecified site
M71.38	Other bursal cyst, other site
M71.39	Other bursal cyst, multiple sites
M72.1	Knuckle pads
M72.2	Plantar fascial fibromatosis
M72.4	Pseudosarcomatous fibromatosis
M72.8 – M72.9	Fibroblastic disorders
M75.80 – M75.92	Other shoulder lesions and shoulder lesion, unspecified
M76.10 – M76.12	Psoas tendinitis, side
M76.20 – M76.22	Iliac crest spur, hip
M76.30 – M76.32	Iliotibial band syndrome
M76.60 – M76.62	Achilles tendinitis
M76.70 – M76.72	Peroneal tendinitis
M76.811 – M76.899	Other specified enthesopathies of lower limb, except foot
M76.861 – M76.869	Other enthesopathies, lower leg
M77.00 – M77.02	Medial epicondylitis, elbow
M77.10 – M77.12	Lateral epicondylitis, elbow
M77.30 – M77.32	Calcaneal spur
M77.40 – M77.42	Metatarsalgia,foot
M77.50 – M77.52	Other enthesopathy, foot
M77.9	Enthesopathy, unspecified
M79.3	Panniculitis, unspecified
M79.601 – M79.676	Pain in limb
M79.7	Fibromyalgia

REIMBURSEMENT INFORMATION:

The total number of procedures (20552 and 20553), in any combination, is limited to four (4) in a 30-day period and (6) in six months, per anatomic location.

NOTE: Services in excess of the limitations shown above are subject to medical review of documentation for determination of medical necessity. The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, treatment plan, current medications and/or history of medication use, physical therapy assessment and/or progress notes.

LOINC Codes:

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or

			fewer before starting date of service for the claim.
Attending physician visit note	18733-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Treatment plan	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Current, discharge, or administered medications	34483-8	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physical therapy initial assessment	18735-1	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physical therapy progress note	11508-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage: The following Local Coverage Determination (LCD) was reviewed on the last guideline reviewed date: Injection of Trigger Points (L33912) located at cms.gov.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request

DEFINITIONS:

Anesthetic agent: a drug that causes loss of feeling in a part of the body (local, topical anesthesia), or loss of feeling in the entire body and loss of consciousness (general anesthesia).

Dry needling: the insertion of a needle into a trigger point without injecting any medication, to try to deactivate the trigger point; the needle is removed and the procedure is often followed by stretching exercises.

Steroid agent: a substance also referred to as corticosteroid, similar to hormones produced by the adrenal gland that fight stress associated with illness and injury; they reduce inflammation and affect the immune system.

Trigger point: areas of taut muscle bands or palpable knots of the muscle, that are painful on compression and can produce referred pain, referred tenderness, and/or motor dysfunction.

RELATED GUIDELINES:

Diagnosis and Treatment of Temporomandibular Joint Disorder, 02-20000-12

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 06/27/24.

GUIDELINE UPDATE INFORMATION:

09/15/03	Developed separate MCG created for Tendon Sheath, Ligament and Trigger Point Injections from Outpatient Pain Management 02-61000-01.
01/01/04	Annual HCPCS coding update.
09/15/05	Review and revision of guideline consisting of updated references.
07/15/07	Review, current coverage maintained, guideline reformatted, references updated.
11/15/07	Review and revision of guideline consisting of updated references and addition of diagnosis codes.
01/01/09	Annual HCPCS coding update: revised descriptor for 20552 and 20553.
05/15/09	Scheduled review: update of position statement to include coverage criteria, update of description section to include medical necessity management statement, update reimbursement statement, and references.
09/15/09	Unscheduled review. Update position statement for trigger point injections.
10/15/10	Revision; related ICD-10 codes added.
07/01/11	Revision; formatting changes.
08/15/11	Scheduled review, revise description and ICD9 coding sections; update references, formatting changes.
04/01/12	Revision; updated ICD10 coding with new and revised codes.
09/15/13	Unscheduled review. Revised description, position statement, reimbursement section, program exceptions section and definitions. Updated references. Reformatted guideline.

10/01/15	Revision; updated ICD9 and ICD10 coding sections.
11/01/15	Revision: ICD-9 Codes deleted.
01/01/16	Annual CPT/HCPCS coding update. Revised code 20553 descriptor. Revised Program Exceptions section.
10/01/18	ICD10 coding update: deleted M79.1. Reformatted guideline.
10/15/19	Scheduled review. Revised description and reimbursement information section. Maintained position statement and updated references.
01/01/20	Annual CPT/HCPCS coding update. Added 20560, 20561.
08/15/21	Scheduled review. Revised description and position statement. Updated references.
10/01/21	Quarterly CPT/HCPCS coding update: added codes M54.50, M54.51, M54.59; deleted code M54.5.
05/23/23	Update to Program Exceptions section.
08/15/23	Scheduled review. Revised description, CPT coding, ICD10 coding, and definitions. Deleted criteria for tendon sheath and ligament injections. Revised criteria for trigger point injections. Updated references.
07/15/24	Scheduled review. Revised description. Maintained position statement and updated references.