

Medical Coverage Policy | Dry Needling of Myofascial Trigger Points



EFFECTIVE DATE: 06 | 21 | 2016

POLICY LAST UPDATED: 03 | 07 | 2017

OVERVIEW

Trigger points are discrete, focal, hyperirritable spots within a taut band of skeletal muscle fibers that produce local and/or referred pain when stimulated. Dry needling refers to a procedure whereby a fine needle is inserted into the trigger point to induce a twitch response and relieve the pain.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

Dry needling of trigger points for the treatment of myofascial pain is considered not medically necessary. Dry needling is associated with a high incidence of mild adverse events and the evidence is insufficient to determine the effects of the technology on health outcomes.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable not medically necessary benefits/coverage.

BACKGROUND

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 (e.g., 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 physiological basis for dry needling depends on the targeted tissue and treatment objectives. The most studied targets are 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.¹ Trigger points can be visualized by magnetic resonance imaging and elastography. Reliability of manual identification of trigger points has not been established.

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.¹ 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 physiological basis for dry needling treatment of excessive muscle tension, scar tissue, fascia, and connective tissues is not as well described in the literature.¹

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.

For individuals who have trigger points associated with myofascial pain who receive dry needling of trigger points, the evidence includes a number of randomized controlled trials and systematic reviews. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Overall, dry needling of trigger points has not been shown to be clinically superior to sham treatment or manual therapy. In addition, dry needling is associated with a high incidence of mild adverse events. The evidence is insufficient to determine the effects of the technology on health outcomes.

CODING

There is currently no specific CPT code for dry needling. Claims should be submitted with the unlisted code 20999.

Dry needling is not acupuncture, therefore CPT codes 97810-97814 are not appropriate to be used for this service.

RELATED POLICIES

None

PUBLISHED

Provider Update, May 2017

Provider Update, September 2016

REFERENCES

1. American Physical Therapy Association (APTA). Educational resource paper: Description of Dry Needling in Clinical Practice. 2013; <http://www.aaompt.org/documents/dryneedlinginptclinicalpracticeeducationalresourcepaper.pdf>. Accessed December 31, 2015.
2. Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. *Am Fam Physician*. Feb 15 2002;65(4):653-660. PMID 11871683
3. Cagnie B, Castelein B, Pollie F, et al. Evidence for the use of ischemic compression and dry needling in the management of trigger points of the upper trapezius in patients with neck pain: a systematic review. *Am J Phys Med Rehabil*. Jul 2015;94(7):573-583. PMID 25768071
4. Llamas-Ramos R, Pecos-Martin D, Gallego-Izquierdo T, et al. Comparison of the short-term outcomes between trigger point dry needling and trigger point manual therapy for the management of chronic mechanical neck pain: a randomized clinical trial. *J Orthop Sports Phys Ther*. Nov 2014;44(11):852-861. PMID 25269764
5. 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*. 2010;3:18. PMID 20807448
6. 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):1083-1094. PMID 24700136
7. 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):285-290. PMID 23220812
8. 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):134-140. PMID 25125935
9. American Physical Therapy Association (APTA). Guidelines: Physical therapist scope of practice BOD G02-14-18-12. 2012;

https://www.google.com/?gws_rd=ssl#safe=active&q=2009+apta+position+statement+on+dry+needling. Accessed December 31, 2015.

10. American Academy of Orthopaedic Physical Therapists. AAOMPT position statement on dry needling, 2009; <https://www.aaompt.org/about/statements.cfm>. Accessed December 31, 2015.

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

