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Note: Although the services described in this position statement are not subject to routine medical necessity review, utilization may be audited.

Clinical Position Statement: Trigger Point Therapy

The American Society of Interventional Pain Physicians (ASIPP) and Medicare medical policy provides the following description of trigger points and trigger point therapy: (1, 2)

Trigger points or trigger zones are self-sustaining, hyper-irritative foci that may occur in any skeletal muscle on the body. These trigger points are particularly sensitive to touch and when stimulated, become the site of a painful neuralgia. Trigger points produce a referred pain pattern characteristic for that individual muscle which is sometimes remote from the point itself and not related to it by anatomically definable pathways. Usually, the involved muscle is felt as a tight palpable band. Frequently affected sites include the trapezius, supraspinatus, infraspinatus, teres major, lumbar paraspinals (2 sites), gluteus and pectoralis muscles.

There is no laboratory or imaging test for establishing the diagnosis of trigger points. It depends upon the detailed history and a thorough directed examination.

Injections of substances such as anesthetic and/or steroids are done to affect therapy for the pathological condition.

- There is sufficient evidence to suggest that up to four trigger point injection sessions per body area per year may be effective as a treatment of chronic low back pain and myofascial pain syndrome when:
 - Trigger points have been identified by palpation; and
 - Symptoms have persisted for more than three months; and
 - Medical management therapies such as bed rest, exercises, physical therapy, non-steroidal anti-inflammatory medications (unless contraindicated) and muscle relaxants have failed to control pain.

- The frequency of injections should be two months or longer between injection sessions

provided that greater than 50% pain relief is obtained for six weeks. (1)

- Body areas as defined by CPT Evaluation and Management guidelines are:
 - Abdomen
 - Back
 - Chest, including breast and axilla
 - Each extremity
 - Genitalia, groin, buttocks
 - Head, including the face
 - Neck
- There is insufficient evidence to determine the effectiveness of dry needle stimulation and trigger point injections with any substances other than local anesthetic with or without steroid (e.g., saline, magnesium sulfate, or glucose).

Rationale:

- There is a lack of evidence from published clinical trials documenting the frequency and number of trigger point injections. The ASIPP consensus-based guidelines for pain management advocate as many as eight trigger point injections per body area per year; however, this number is not supported by clinical trial data. (1) Therefore, conclusions cannot be made concerning the effectiveness of more than four trigger point injections per year per body area.
- Due to insufficient scientific evidence that dry needling or injection of saline, magnesium sulfate, or glucose at trigger point sites affects pain of patients with myofascial pain syndromes or tension headaches, conclusions cannot be reached concerning their effect on health outcomes.

Representative studies of trigger point injection include the following:

- 102 patients with chronic trigger point pain of the upper trapezius muscle were randomized to ultrasound and neck stretching exercises (group 1); trigger point injections and neck stretching exercises (group 2); or neck stretching exercises alone (control group). Compared with the control group, patients in groups 1 and 2 had a statistically significant reduction in pain intensity, an increase in pressure pain threshold, and an increase in range of motion. There were no statistically significant differences in outcomes between groups 1 and 2. (3)
- 15 patients were randomized to dry needle trigger point therapy at 6 trigger point sites or to sham dry needle therapy. (4) Mean headache indices improved in both the experimental group and the sham therapy group, however the difference was not statistically significant. In the dry needle trigger point group neck tenderness and neck range-of-motion improved more than in the sham treated group; however, the number of patients treated was too small for the difference to reach statistical significance.
- 45 patients with headaches and at least one myofascial pain trigger point to the neck or head were randomized to receive dry needling, trigger point injection using lidocaine, or trigger point injection using lidocaine and a steroid medication. (5) Results from this study are unreliable

due to the following:

- There was no stated blinding in this study which may lead to both patient and investigator bias.
- There was no mention of intention-to-treat analysis. Without this analysis, bias may be introduced which creates an impression of benefit in favor of the treatment under study.
- Three out of four of the outcome measures were subjective (patient reported), which may lead to patient treatment bias.

References

1. Manchikanti L, Singh V, Kloth D. American Society of Interventional Pain Physicians Practice Guidelines. Interventional techniques in the management of chronic pain: part 2.0. *Pain Physician* 2001;4(1):24-24-98
2. LCD for Trigger Point Injections (L23773)
http://www.cms.hhs.gov/MCD/viewlcd.asp?lcd_id=23773&lcd_version=4&show=all
(verified 3/24/09)
3. Esenyel et al. Treatment of Myofascial Pain. *Am J Phy Med Rehabil* Jan-Feb 2000;79:48-52
4. Karakurum B, Karaalin O, Coskun O et al. The 'dry-needle' technique: intramuscular stimulation in tension-type headache. *Cephalgia* 2001;21(8):813-7
5. Venancio RA, Alencar FG et al. Different Substances and Dry-Needling Injections in Patients with Myofascial Pain and Headaches. *The Journal of Craniomandibular Practice* 2008; 26(2): 96-103.

Cross References

[Facet Joint Injections](#), Regence Medical Policy, Surgery, No. 135

Codes	Number	Description
CPT	20552	Injection(s); single or multiple trigger point(s), one or two muscle(s)
	20553	Injections; single or multiple trigger point(s), three or more muscle(s)
HCPCS	None	