Anthem

Clinical UM Guideline

Subject: Trigger Point Injections
Guideline #: CG-SURG-17
Status: Reviewed

Publish Date: 06/28/2023
Last Review Date: 05/11/2023

Description

This document addresses trigger point injections.

Trigger points are small, circumscribed, hyperirritable foci in muscles, often found within a firm or taut band of skeletal muscle. Frequently affected sites include the trapezius, supraspinatus, infraspinatus, teres major, lumbar paraspinals, gluteus and pectoralis muscles. The diagnosis is clinical and depends upon the results of a detailed history and a thorough directed exam. There is no laboratory or imaging test to establish the diagnosis of trigger point pain.

Myofascial pain syndrome is a regional painful muscle condition with a relationship between a specific trigger point and its associated pain region. When myofascial pain syndrome is suspected, injections of local anesthetics with or without steroid into the identified trigger points have been used for myofascial pain management for many years within the medical community.

Clinical Indications

Medically Necessary:

I. Trigger point injections with a local anesthetic, with or without steroid, are considered **medically necessary** when *all* of the following general and specific criteria are met:
   A. General Criteria
      1. There is a regional pain complaint; **and**
      2. A neurological, orthopedic, or musculoskeletal system evaluation, which includes the individual's description of pain as it relates to location, quality, severity, duration, timing, context, and modifying factors, followed by a physical examination of associated signs and symptoms; **and**
      3. Conservative therapy (for example, physical or chiropractic therapy, oral analgesia, steroids, relaxants or activity modification) fails or is not feasible; **and**
      4. When necessary to facilitate mobilization and return to activities of daily living, an aggressive regimen of physical therapy or other therapeutic modalities has been implemented.
   B. Specific Criteria
      1. Pain complaint or altered sensation in the expected distribution of referred pain from a trigger point; **and**
      2. Taut band palpable in an accessible muscle when the trigger point is myofascial; **and**
      3. Exquisite spot tenderness at one point along the length of the taut band when the pain is myofascial; **and**
      4. Some degree of restricted range of motion of the involved muscle or joint, when measurable; **and**
      5. The above specific criteria are associated with at least ONE of the following MINOR CRITERIA:
         a. Reproduction of clinical pain complaint or altered sensation by pressure on the tender spot; **or**
         b. Local response (twitch) elicited by snapping palpation at the tender spot or by needle insertion into the tender spot; **or**
         c. Pain alleviation by elongating (stretching) the muscle or by injecting the tender spot.

II. Trigger point injections with a local anesthetic, with or without steroid, are considered **medically necessary** for the treatment of pain associated with fibromyalgia when *all* of the following criteria have been met:
   A. Wide spread pain index (WPI) ≥7 and symptom severity scale (SSS) score ≥ 5 **OR** WPI of 4–6 and SSS score ≥9; **and**
   B. Generalized pain, defined as pain in at least 4 of 5 regions, must be present. (Note that jaw, chest, and abdominal pain are not included in generalized pain definition); **and**
   C. Symptoms have been present for at least 3 months.

III. The following schedule for trigger point injections is considered **medically necessary** when the medically necessary criteria above have been met:
   A. In the diagnostic or stabilization phase, individuals may receive injections at intervals of no sooner than one week and preferably two weeks. The number of trigger point injections should be limited to no more than four (4) times per year for the diagnostic or stabilization phase.
   B. In the treatment or therapeutic phase, trigger point injections should continue only if the previous diagnostic injections provided pain relief and the frequency should be two (2) months or longer between each injection. The previous injections should have provided at least greater than 50% relief of pain for a period of at least six (6) weeks. The injections should be repeated only as necessary based on the medical necessity criteria (see above) and these should be limited to a maximum of six (6) times for local anesthetic and steroid injections.
   C. Under unusual circumstances such as a recurrent injury or cervicogenic headache, trigger point injections may be repeated at intervals of six (6) weeks after stabilization in the treatment phase.

Not Medically Necessary:

I. Trigger point injections are considered **not medically necessary** in the presence of:
   A. Systemic infections; **or**
   B. Bleeding tendencies (including individuals undergoing anticoagulation therapy); **or**
   C. Other concomitant unstable medical conditions.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
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

ICD-10 Diagnosis	
G44.201-G44.229	Tension-type headache
G89.0	Central pain syndrome
G89.11-G89.18	Acute pain, not elsewhere classified
G89.21-G89.29	Chronic pain, not elsewhere classified
G89.4	Chronic pain syndrome
M25.50-M25.59	Pain in joint
M26.621-M26.629	Arthralgia of temporomandibular joint
M54.2	Cervicalgia
M54.50-M54.59	Low back pain
M70.80-M70.99	Other/unspecified soft tissue disorders related to use, overuse or pressure
M79.10-M79.18	Myalgia (myofascial pain syndrome)
M79.601-M79.676	Pain in limb, hand, foot, fingers and toes
M79.7	Fibromyalgia

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met or for all other diagnoses not listed, or for situations designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Although not supported by rigorous randomized controlled trials (Cummings 2001), trigger point injections with a local anesthetic with or without a steroid are considered an accepted therapy for pain associated with myofascial pain syndrome or fibromyalgia syndrome.

In a Cochrane review, Peloso and colleagues (2011) examined the effects of medication and injections on primary outcomes (for example, pain) for adults with mechanical neck disorders and whiplash. In their data analysis, they found that lidocaine injection into myofascial trigger points appears effective in two trials.

In another Cochrane review, Staal and colleagues (2011) performed a data analysis to determine if injection therapy is more effective than placebo or other treatments for individuals with subacute or chronic low-back pain. Based on these results, the review authors concluded that there is no strong evidence for or against the use of any type of injection therapy for individuals with subacute or chronic low-back pain.

Kim and colleagues (2012) evaluated the therapeutic effectiveness of trigger point injections into the muscles around the groin in males with clinically diagnosed chronic prostatitis (CP) and chronic pelvic pain syndrome (CPPS). A total of 21 participants ranging in ages from 20 to 61 years met the inclusion criteria. The National Institute of Health- Chronic Prostatitis Symptom Index (NIH-CPSI) score and the visual analog scale for pain (VAS) were the main outcome measurements. Trigger point injections were performed in all affected muscles at 1-week intervals. Additional injections were not considered if the participants were satisfied with the reduction in discomfort or the severity of pain, or if the individual did not want another injection for other reasons. No other therapies (such as physical therapy or medications) were allowed during the study period. However, self-exercise and behavior correction were allowed to avoid early recurrence of pain after trigger point injections. All participants completed the treatment schedule and attended a follow-up, 66.7% (14/21) received 1 trigger point injection, 28.6% (6/21) received 2 injections and 1 participant received 3 injections. The majority of participants (19/21) reported symptom improvement and no need for further treatment. The treatment module was not completed by 2 participants, citing personal reasons. The VAS and NIH-CPSI scores decreased compared to baseline in all participants. There were no reported associated complications or serious adverse events. The authors concluded that US-guided trigger point injections of the iliopsoas, hip adductor, and abdominal muscles are safe and effective for CP/CPPS groin pain which is believed to originate from muscles. The iliopsoas muscle was affected in all of the participants in this study. The authors acknowledged that limitations of this study include its small size and short follow-up time.

Fernández-de-Las-Peñas (2018) published a consensus report on the diagnostic criteria for myofascial trigger points resulting from a Delphi panel of 60 experts from 12 countries. The results reported that at least two of the following diagnostic trigger point criteria must be present for a proper diagnosis: 1) a taut band, 2) a hypersensitive spot, and 3) referred pain. They noted that pain referral from a myofascial trigger point may include different sensory sensations, including pain spreading to a distant area, deep pain, dull ache, tingling, or burning pain. They proposed the use of the term “referred sensation” as an addition to “referred pain”.

Nouged and associates (2019) published a meta-analysis evaluating the effectiveness of local anesthetic trigger point injections in adults with myofascial pain syndrome of the head, neck or shoulder. The authors compared the trigger point injections to dry needling or placebo. A total of 11 randomized control trials (RCTs) were included in the meta-analysis. Participants of all included studies had a diagnosis of myofascial pain. The primary outcome measure was pain assessed using a VAS. In a comparison of double-blind studies, the improvement in VAS post-treatment in the trigger point injection sample compared to the dry needling sample was not statistically significant. While the trigger point injection group post-treatment VAS scores did show an improvement over placebo, the difference did not reach clinical significance. There are several limitations associated with this study. Sample sizes were small with heterogeneous populations, provider types, muscles treated, and interventions used. Risk of bias was judged to be high in 10 of the 15 included studies. Many of the studies did not control for the use of and adherence to concurrent therapies. The authors note:

> The findings support the common practice of utilizing TrP [trigger point] injections after failure of noninvasive treatment modalities such as patient education, change in lifestyle, physical therapy, and medications; however, additional studies with larger numbers of participants, clearly monitored home treatments, and minimal risk of bias are needed to confirm these results.

The American College of Rheumatology (ACR) has published a series of recommendations regarding the diagnostic criteria for fibromyalgia (Wolfe, 1990, 2010, and 2016). The latest version, published in 2016, reflects an evolution in the understanding of this condition. Their recommendations are composed or two main components; the symptom severity scale (SSS) scale, which permits the evaluation of the severity of fibromyalgia symptoms, and the Widespread Pain Index (WPI) score which is a self-reported measure that is used to assess pain distribution in addition to the severity of six pain-specific symptoms. These symptoms include fatigue, memory difficulties, tiredness, headache, abdominal pain, and depression.

The SSS score is a calculated by adding the sum total of severity levels for 3 symptom groups over the past week (fatigue, feeling unrefreshed upon awaking and symptoms involving cognition) in addition to the extent (severity) of somatic symptoms in general. The

final score will range from 0 to 12. The first component of the SSS, the symptom measures, are measured on a scale of 0-3:

- No problem
- Slight or mild problems, generally mild or sporadic
- Moderate, considerable problems, frequently present and/or at a moderate level
- Severe: pervasive, constant, life-disturbing problems

The WPI score is determined by noting the number of pre-specified areas in which the individual has had pain during the last week (the total number of areas in which the individual has had pain). The cumulative score will be between 0 and 19. The areas are divided into 5 body areas and include the following:

- Left upper region (Region 1): Left jaw, left shoulder girdle, left upper arm, left lower arm
- Right upper region (Region 2): Right jaw, right shoulder girdle, right upper arm, right lower arm
- Left lower region (region 3): Left hip (buttock, trochanter), left upper leg, left lower leg
- Right lower region (Region 4): Right hip (buttock, trochanter), right upper leg, right lower leg,
- Axial region (Region 5): Neck, upper and lower back, chest, abdomen

The fibromyalgia severity (FS) scale is the sum of the WPI and SSS. The FS scale is also known as the polysymptomatic distress (PSD)scale.

References

Peer Reviewed Publications:

1. Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. Am Fam Physician. 2002; 15; 65(4):653-660.
2. Cummings TM, White AR. Needling therapies in the management of myofascial trigger point pain: a systematic review. Arch Phys Med Rehabil. 2001; 82(7):986-992.
3. Galvez-Sánchez CM, Reyes Del Paso GA. Diagnostic criteria for fibromyalgia: Critical review and future perspectives. J Clin Med. 2020; 9(4):1219.
4. Huguenin L. Myofascial trigger points: the current evidence. Physical Therapy in Sport 5. 2004; 2-12.
5. Kim DS, Jeong TY, Kim YK, et al. Usefulness of a myofascial trigger point injection for groin pain in patients with chronic prostatitis/chronic pelvic pain syndrome: a pilot study. Arch Phys Med Rehabil. 2013; 94(5):930-936.
6. Fernández-de-Las-Peñas C, Dommerholt J. International consensus on diagnostic criteria and clinical considerations of myofascial trigger points: A Delphi Study. Pain Med. 2018; 19(1):142-150.
7. Nouged E, Dajani J, Ku B, et al. Local Anesthetic Injections for the short-term treatment of head and neck myofascial pain syndrome: a systematic review with meta-analysis. J Oral Facial Pain Headache. 2019; 33(2):183-198.

Government Agency, Medical Society, and Other Authoritative Publications:

1. American Society of Anesthesiologists (ASA), American Society of Regional Anesthesia (ASRA). Practice guidelines for chronic pain management: an updated report Anesthesiology 2010; 112(4):810-833.
2. American College of Occupational and Environmental Medicine (ACOEM). Chronic pain. In: Occupational medicine practice guidelines: evaluation and management of common health problems and functional recovery in workers. 2008; 73-502.
3. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidiscilpinary Spine Care. Diagnosis and Treatment of Low Back Pain. 2020. Available at: https://www.spine.org/Portals/0/assets/downloads/ResearchClinicalCare/Guidelines/LowBackPain.pdf. Accessed on April 12, 2023.
4. Peloso PMJ, Gross A, Haines T, et al. Medicinal and injection therapies for mechanical neck disorders Cochrane Database Syst Rev. 2007, updated 2011;(4):CD000319.
5. Resnick D, Choudhri T, Dailey A, et al.: American Association of Neurological Surgeons. Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 13: injection therapies, low-back pain, and lumbar fusion. J Neurosurg: Spine 2005; 2(6):707-715.
6. Scott A, Guo B. Trigger Point Injections for Chronic Non-Malignant Musculoskeletal Pain Health Technology Assessment (HTA) number 35. Alberta Heritage Foundation for Medical Research. 2005.
7. Staal JB, de Bie R, de Vet HCW, et al. Injection therapy for subacute and chronic low-back pain. Cochrane Database Syst Rev. 2008, updated 2011;(3):CD001824.
8. Wolfe F, Clauw DJ, Fitzcharles MA, et al. The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. Arthritis Care Res (Hoboken). 2010; 62(5):600-610.
9. Wolfe F, Clauw DJ, Fitzcharles MA, et al. 2016 Revisions to the 2010/2011 fibromyalgia diagnostic criteria. Semin Arthritis Rheum. 2016; 46: 319-329.
10. Wolfe F, Smythe HA, Yunus MB, et al. The American College of Rheumatology. 1990 criteria for the classification of fibromyalgia: Report of the multicenter criteria committee. Arthritis Rheum. 1990; 33(2):160-172.

Index

History

Status	Date	Action
Reviewed	05/11/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Discussion and References sections.
Revised	05/12/2022	MPTAC review. Clarification of the trigger point injection MN general criteria. Revised MN statement for fibromyalgia treatment. Moved measurement scale information and specialty society recommendations to the Discussion section. Updated Discussion and References sections.
	10/01/2021	Updated Coding section with 10/01/2021 ICD-10-CM changes; added M54.50-M54.59 replacing M54.5 deleted 09/30/2021.
Reviewed	05/13/2021	MPTAC review. Updated Discussion and References sections. Reformatted Coding section and added diagnosis codes.
Reviewed	05/14/2020	MPTAC review. Updated References.

Revised	06/06/2019	MPTAC review. Revised document so that it no longer addresses dry needling. Updated the Description, Clinical Indications, Coding, Discussion/General Information, References and Index sections by removing information related to dry needling.
Reviewed	03/21/2019	MPTAC review. Updated review date and History sections.
Reviewed	05/03/2018	MPTAC review. The document header wording updated from “Current Effective Date” to “Publish Date.” Updated review date, Rationale, References and History sections.
Revised	05/04/2017	MPTAC review. Updated formatting in the Clinical Indications section. In the Not Medically Necessary statement, inserted the word “or” after bullets IA and IB. Updated review date, Coding, and History sections.
Reviewed	05/5/2016	MPTAC review. Updated review date, References and History sections.
	01/01/2016	Updated Coding section with 01/01/2016 descriptor change for CPT 20553; removed ICD-9 codes.
Revised	05/07/2015	MPTAC review. Expanded the medically necessary criteria for trigger point injections for individuals with fibromyalgia to include the 2010 ACR criteria. Updated review date, Discussion/General Information, References and History sections.
Reviewed	05/15/2014	MPTAC review. Updated References section.
Reviewed	05/09/2013	MPTAC review. Updated Discussion/General Information and References sections.
Reviewed	05/10/2012	MPTAC review. Discussion and References sections updated.
Reviewed	05/19/2011	MPTAC review. References and Coding sections updated.
Reviewed	05/13/2010	MPTAC review. References section updated.
Reviewed	05/21/2009	MPTAC review. Discussion and References sections updated. Place of service removed.
Reviewed	05/15/2008	MPTAC review. References section updated.
Revised	05/17/2007	MPTAC review. Guideline revised to address dry needling. Background, Coding, and References section updated.
Reviewed	12/07/2006	MPTAC review. References section updated.
Revised	12/01/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.			None
Anthem BCBS			None
WellPoint Health Networks, Inc.	12/02/2004	Guideline	Regional Anesthesia/Pain Management for Chronic Neck, Back and Myofascial Pain

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.