*Current Policy Effective Date: 5/1/25
(See policy history boxes for previous effective dates)

Title: Dry Needling of Trigger Points for Myofascial Pain

Description/Background

Dry Needling

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

Regulatory Status

Dry needling is considered a procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

Medical Policy Statement

Dry needling of myofascial trigger points is experimental/investigational. It has not been scientifically demonstrated to improve patient clinical outcomes.

Inclusionary and Exclusionary Guidelines

N/A

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

N/A

Other codes (investigational, not medically necessary, etc.):

20560 20561 20999

Note: Codes 97810-97814 are not appropriate since this is not the same as acupuncture

Note: Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function-including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Dry Needling of Trigger Points Associated with Neck and/or Shoulder Pain

Clinical Context and Therapy Purpose

The purpose of dry needling in individuals who have myofascial neck and/or shoulder pain is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following **PICO** was used to select literature to inform this review.

Populations

The relevant population of interest are individuals with myofascial trigger points associated with neck, shoulder pain. Trigger points are discrete, focal, hyperirritable spots within a taut band of skeletal muscle fibers that produce local and/or referred pain when stimulated.

Interventions

The therapy being considered is dry needling.

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. The needle may be moved in an up-and-down motion, rotated, and/or left in place for as long as 30 minutes. The physiologic basis for dry needling depends on the targeted tissue and treatment objectives. Deep dry needling is believed to inactivate trigger points by eliciting contraction and subsequent relaxation of the taut band via a spinal cord reflex. Superficial dry needling is thought to activate mechanoreceptors and have an indirect effect on pain by inhibiting C-fiber pain impulses.

Comparators

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.[2]

Outcomes

The outcomes of interest are symptoms, functional outcomes, QOL, and treatment-related morbidity.

Review of Evidence

Systemic Reviews

Numerous, primarily small, RCTs involving dry needling techniques in neck or shoulder pain have been evaluated in several systematic reviews and meta-analyses.

Charles et al (2019) conducted a systematic review of different techniques for treatment of myofascial pain. [3] A total of 23 studies 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.

Navarro-Santana et al (2020) conducted a systematic review and meta-analysis of dry needling of myofascial trigger points associated with neck pain compared to sham needling, no intervention, or other physical interventions.[4] A total of28 RCTs were included. Dry needling reduced pain immediately after the intervention (mean difference [MD] in pain score-1.53; 95% confidence interval [CI] -2.29 to -0.76) and at the short-term (up to 1 month) (MD -2.31, 95% CI -3.64 to -0.99)when compared with sham, placebo, waiting list, or other forms of dry needling, and at the short-term compared with manual therapy (MD -0.51, 95% CI -0.95 to -0.06). No differences in comparison with other physical therapy interventions were observed. An effect on pain-related disability at the short-term was found when comparing dry needling with sham, placebo, waiting list, or other form of dry needling, but not with manual therapy or other physical therapy interventions.

Navarro-Santana et al (2020) also conducted a systematic review and meta-analysis of dry needling for shoulder pain.[5] The meta-analysis found moderate quality evidence for a small effect (MD -0.49 points; 95% CI -0.84 to -0.13;standardized mean difference [SMD] -0.25; 95% CI -0.42 to -0.09) for decreasing shoulder pain intensity, and low quality evidence for a large effect (MD -9.99 points; 95% CI -15.97 to -4.01; SMD -1.14; 95% CI -1.81 to -0.47) for reducing related disability. The effects on pain intensity were found only in the short term (up to 1 month) and did not reach the minimal clinically important difference of 1.1 points for the numerical pain rating scale (0 to 10) determined for patients with shoulder pain. Confidence intervals of the main effects of dry needling on pain intensity and related disability were wide. Additionally, the trials were heterogeneous with regard to the number and/or frequency of needling sessions and the type of comparator.

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.[16] 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 (SMD, -0.27; 95% CI, -0.49 to -0.05; I2=0.00%; p<.02; 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.

Section Summary: Neck and/or Shoulder Pain
A number of RCTs and systematic reviews of these studies have evaluated dry needling of myofascial trigger points for neck and/or shoulder pain. A systematic review of techniques for myofascial pain included 15 studies of dry needling for neck or shoulder pain published through 2017. Studies had multiple methodological limitations, and the reviewers concluded that the evidence for dry needling was not greater than placebo. In more recent systematic reviews and meta-analyses, dry needling was not associated with clinically important reductions in shoulder or neck pain when compared toother physical therapy modalities.

Dry Needling of Myofascial Trigger Points Associated with Plantar Heel Pain

Review of Evidence

Systemic Review
Llurda-Almuzara et al (2021) published a systematic review of 6 randomized trials (N=395) evaluating dry needling for the treatment of plantar fasciitis (Tables 1 to 3).[6,] None of the included trials were double-blind and, although the authors did find some positive effects of dry needling, the heterogeneity, lack of blinding, and small number of patients in the trials limits applicability.

Table 1. Trials Included in Systematic Review

Study	Llurda-Almuzara et al (2021)[6,]
Bagcier et al (2020)[7,]	●
Cotchett et al (2014)[8,]	●
Eftekharsadat et al (2016)[9,]	●
Rahbar et al (2018)[10,]	●
Rastegar et al (2017)[11,]	●
Uygur et al (2019)[12,]	●

Table 2. Systematic Review Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Llurda-Almuzara et al (2021)[6]	Inception-2020	6	Patients with heel pain receiving dry needling or comparator (placebo, no intervention, or active comparator)	395 (10 to 49)	RCT	1 to 6 sessions (mean, 4 sessions)

RCT: randomized controlled trial.

Table 3. Systematic Review Results

Study	Overall Pain Intensity	Pain Intensity (at least 3 Sessions)	Long-term Pain Intensity	Pain-related Disability
Llurda-Almuzara et al (2021)[6]				
Trials (n)	6	4	2	5
SMD (95% CI)	-0.5 (-1.13 to 0.13)	-1.28 (-2.11 to -0.44)	-1.45 (-2.19 to -0.70)	-0.46 (-0.90 to -0.01)
I^2	94%	>85%	67% to 78%	84%

CI: confidence interval; SMD: standardized mean difference.

Section Summary: Plantar Heel Pain

The evidence base consists of a systematic review of RCTs. The authors included 6 randomized trials enrolling 395 patients and found no overall difference in pain intensity in those treated with dry needling compared with active control, placebo, or no intervention. However, pain intensity after at least 3 sessions, long-term pain intensity, and pain-related disability were improved. The systematic review rated the quality of the studies it assessed as low to moderate. The evidence is limited by small patient populations and lack of blinding; therefore, additional RCTs are needed to strengthen the evidence base.

Dry Needling of Myofascial Trigger Points Associated with Temporomandibular Pain

Review of Evidence

Randomized Controlled Trials

Garcia-de-la-Banda-Garcia et al (2023) conducted an RCT that compared dry needling to manual therapy in 50 individuals with temporomandibular disorders.[18] 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.

A double-blind, sham-controlled trial of dry needling for the treatment of temporomandibular myofascial pain was reported by Diracoglu et al (2012).[13] Patients (N=52) with symptoms for at least 6 weeks with 2 or more myofascial trigger points in the temporomandibular muscles were included in the trial. Trigger points were stimulated once weekly over three weeks. The sham condition involved dry needling in areas away from the trigger points. Patients were evaluated one week after the last needling. At follow-up, there was no significant difference between groups in pain scores assessed by a 10-point VAS. Mean VAS scores were 3.88 in the treatment group and 3.80 in the control group (p=.478). Also, the difference in unassisted jaw opening without pain did not differ significantly between the treatment group (40.1 mm) and the control group (39.6 mm; p=.411). The mean pain pressure threshold was significantly higher in the treatment group (3.21 kg/cm^2) than in the control group (2.75 kg/cm^2; p<.001).

Section Summary: Temporomandibular Myofascial Pain
Two RCTs evaluating dry needling for the treatment of temporomandibular myofascial pain were identified; One trial was double-blind and sham-controlled. One week after completing the intervention, there were no statistically significant differences between groups in pain scores or function (unassisted jaw opening without pain). There was a significantly higher pain pressure threshold in the treatment group. This RCT does not provide sufficient evidence on which to draw conclusions about the impact of dry needling on health outcomes in patients with temporomandibular myofascial pain. The second RCT was active-controlled, but quality is limited by lack of blinding and a small sample size.

Adverse Events
A prospective survey (2014) of 39 physical therapists, providing 7629 dry needling treatments, reported 1463 (19.18%) mild adverse events (bruising, bleeding, pain) and no serious adverse events.[14]

Summary of Evidence
For individuals who have myofascial trigger points associated with neck and/or shoulder pain who receive dry needling of trigger points, the evidence includes randomized controlled trials (RCTs) and systematic reviews. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. A systematic review of techniques to treat myofascial pain included 15 studies of dry needling for neck or shoulder pain published through 2017. Studies had multiple methodological limitations, and the reviewers concluded that the evidence for dry needling was not greater than placebo. In more recent systematic reviews and meta-analyses, dry needling was not associated with clinically important reductions in shoulder or neck pain when compared to other physical therapy modalities. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have myofascial trigger points associated with plantar heel pain who receive dry needling of trigger points, the evidence includes a systematic review of randomized trials. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The systematic review included 6 randomized trials enrolling 395 patients and found no overall difference in pain intensity in those treated with dry needling compared with active control, placebo, or no intervention. However, pain intensity after at least 3 sessions, long-term pain intensity, and pain-related disability were improved. The systematic review rated the evidence as low to moderate. The evidence for dry needling in patients with plantar heel pain is limited by small patient populations and lack of blinding; therefore,

additional good methodological quality RCTs are needed to strengthen the evidence base. The evidence is insufficient to determine that the technology results in the net health outcome.

For individuals who have myofascial trigger points associated with temporomandibular myofascial pain who receive dry needling of trigger points, the evidence includes RCTs. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. One double-blind, sham-controlled randomized trial was identified; it found that one week after completing the intervention, there were no statistically significant differences between groups in pain scores or function (unassisted jaw opening without pain). There was a significantly higher pain pressure threshold in the treatment group. The second RCT (N = 50) compared dry needling to manual therapy. 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). Methodological quality was limited by a lack of blinding and no reporting of power/sample size calculation. Additional RCTs, especially those with a sham-control group, are needed. The evidence is insufficient to determine that the technology results in the net health outcome.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in ‘Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Orthopaedic Manual Physical Therapists

The American Academy of Orthopaedic Physical Therapists (2009) issued a statement that dry needling fell within the scope of physical therapist practice.[15] In support of this position, the Academy stated that “dry needling is a neurophysiological evidence-based treatment technique that requires effective manual assessment of the neuromuscular system…. Research supports that dry needling improves pain control, reduces muscle tension, normalizes biochemical and electrical dysfunction of motor endplates, and facilitates an accelerated return to active rehabilitation.”

American Physical Therapy Association

In 2023, the American Physical Therapy Association published an updated guideline on nonarthritic heel pain (plantar fasciitis).[19] The guideline stated that dry needling of myofascial trigger points in the following areas should be used: gastrocnemius, soles, and plantar muscles of the foot. The evidence supports the efficacy of this technique for pain and long-term function and improved disability, especially in patients with chronic heel pain (defined as lasting more than 1 month). The recommendation was based in part on the systematic review conducted by Llurda-Almuzara discussed above, and more recent studies with methodological limitations including lack of a sham control comparison group.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT06023264	Randomized, Open Clinical Trial to Evaluate the Effect of Dry Needling on the Temporomandibular Joint in Subjects Who Have Suffered a Whiplash as a Result of a Traffic Accident	50	May 2024
NCT04726683	Trigger Point Dry Needling vs Injection in Patients With Temporomandibular Disorders: A Randomized Placebo-controlled Trial	64	Dec 2024
NCT06074640	Effects of Post Isometric Relaxation With and Without Dry Needling in Triceps Surae With Chronic Heel Pain	42	Apr 2024
NCT05915091	Comparative Effects of Dry Needling and Cross Friction Massage on Patients With Plantar Fascitis, a Randomized Controlled Trial	60	Aug 2023
NCT05810818	Effectiveness Of Dry Needling and Soft Tissue Mobilization Combined With Self-Stretching for Management of Calf and Heel Pain	54	Aug 2023
NCT05868512	Effectiveness of Dry Needling Versus Therapeutic Ultrasound Along With Routine Physical Therapy in Patients With for Chronic Neck Pain; a Randomized Control Trial	31	Aug 2023
NCT05532098	Comparative Efficacy of Platelet Rich Plasma and Dry Needling in Management of Anterior Disc Displacement of Temporomandibular Joint	78	Mar 2023
Unpublished			
NCT04851067	Dry Needling Versus Manual Therapy in Patients With Mechanical Neck Pain: A Randomized Control Trial	75	Mar 2022 (status unknown)
NCT03844802	Effectiveness of Real or Placebo Dry Needling Combined With Therapeutic Exercise in Adults With Chronic Neck Pain	58	Jul 2023
NCT05624515	Efficacy of Dry Needling and Ischaemic Compression of the Scapula Angularis Muscle in Patients With Cervicalgia. Randomised Clinical Trial	80	Jan 2023

NCT: national clinical trial.

Government Regulations

National:

There is no national coverage determination on dry needling of trigger points for myofascial pain.

Local:

There is no local coverage determination on dry needling of trigger points for myofascial pain.

There is a LCD on Trigger Points, Local Injections (L34588, for services on or after 08/31/2023) which addresses only injections and not dry needling.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Myofascial Trigger Point Injections-Dry Needling. Retired 07/01/15.

References

1. American Physical Therapy Association (APTA). Dry Needling. n.d.; https://www.apta.org/patient-care/interventions/dry-needling. Accessed December 7, 2021.
2. Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. Am Fam Physician. Feb 15 2002; 65(4):653-60. PMID 11871683
3. Charles D, Hudgins T, MacNaughton J, et al. A systematic review of manual therapy techniques, dry cupping and dry needling in the reduction of myofascial pain and myofascial trigger points. J Bodyw Mov Ther. Jul 2019; 23(3):539-546. PMID 31563367
4. Navarro-Santana MJ, Sanchez-Infante J, Fernandez-de-Las-Penas C, et al. Effectiveness of Dry Needling for Myofascial Trigger Points Associated with Neck Pain Symptoms: An Updated Systematic Review and Meta-Analysis. J Clin Med. Oct 14 2020; 9(10). PMID 33066556
5. Navarro-Santana MJ, Gomez-Chiguano GF, Cleland JA, et al. Effects of Trigger Point Dry Needling for Nontraumatic Shoulder Pain of Musculoskeletal Origin: A Systematic Review and Meta-Analysis. Phys Ther. Feb04 2021; 101(2). PMID 33340405
6. Llurda-Almuzara L, Labata-Lezaun N, Meca-Rivera T, et al. Is Dry Needling Effective for the Management of Plantar Heel Pain or Plantar Fasciitis? An Updated Systematic Review and Meta-Analysis. Pain Med. Jul 25 2021; 22(7): 1630-1641. PMID 33760098
7. Bagcier F, Yilmaz N. The Impact of Extracorporeal Shock Wave Therapy and Dry Needling Combination on Pain and Functionality in the Patients Diagnosed with Plantar Fasciitis. J Foot Ankle Surg. Jul 2020; 59(4): 689-693. PMID 32340838
8. 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): 1083-94. PMID 24700136
9. Eftekharsadat B, Babaei-Ghazani A, Zeinolabedinzadeh V. Dry needling in patients with

chronic heel pain due to plantar fasciitis: A single-blinded randomized clinical trial. Med J Islam Repub Iran. 2016; 30: 401. PMID 27683642
10. Rahbar M, Kargar A, Eslamian F, Dolatkhah N. Comparing the efficacy of dry needling and extracorporeal shock wave therapy in treatment of plantar fasciitis. J Mazandaran Univ Med Sci. 2018;28(164):53-62.
11. Rastegar S, Baradaran Mahdavi S, Hoseinzadeh B, et al. Comparison of dry needling and steroid injection in the treatment of plantar fasciitis: a single-blind randomized clinical trial. Int Orthop. Jan 2018; 42(1): 109-116. PMID 29119296
12. Uygur E, Aktas B, Eceviz E, et al. Preliminary Report on the Role of Dry Needling Versus Corticosteroid Injection, an Effective Treatment Method for Plantar Fasciitis: A Randomized Controlled Trial. J Foot Ankle Surg. Mar 2019; 58(2): 301-305. PMID 30850099
13. 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):285-90. PMID 23220812
14. 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): 134-40. PMID 25125935
15. American Academy of Orthopaedic Physical Therapists. AAOMPT position statement on dry needling. 2009; http://aaompt.org/Main/About_Us/Position_Statements/Main/About_Us/Position_Statements.aspx?hkey=03f5a333-f28d-4715-b355-cb25fa9bac2c. Accessed January 6, 2023.
16. Para-García G, García-Muñoz AM, López-Gil JF, et al. Dry Needling Alone or in Combination with Exercise Therapy versus Other Interventions for Reducing Pain and Disability in Subacromial Pain Syndrome: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health. Sep 02 2022; 19(17). PMID 36078676
17. Navarro-Santana MJ, Gómez-Chiguano GF, Cleland JA, et al. Effects of Trigger Point Dry Needling for Nontraumatic Shoulder Pain of Musculoskeletal Origin: A Systematic Review and Meta-Analysis. Phys Ther. Feb 04 2021; 101(2). PMID 33340405
18. Koc TA, Bise CG, Neville C, et al. Heel Pain - Plantar Fasciitis: Revision 2023. J Orthop Sports Phys Ther. Dec 2023; 53(12): CPG1-CPG39. PMID 38037331

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through December 30, 2024, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
02/24/03	02/24/03	02/14/03	Joint policy established titled Myofascial Trigger Points
03/21/05	03/21/05	02/28/05	Routine maintenance; policy retired.
07/01/15	04/21/15	05/08/15	Policy taken out of retirement, added information on dry needling, also added to title. Policy re-retired.
5/1/20	2/18/20		Unretired, completely rewritten with focus on dry needling. Remains as E/I service.
5/1/21	2/16/21		Routine maintenance. Reference 4 added. Policy statement unchanged. Title changed from “Dry Needling of Myofascial Trigger Points” to “Dry Needling of Trigger Points for Myofascial Pain”.
5/1/22	2/15/22		Routine maintenance. References added; some references removed. Policy statement unchanged.
5/1/23	2/21/23		Routine maintenance. Policy statement unchanged. Vendor Review: NA. (ky)
5/1/24	2/20/24		Routine maintenance. Policy statement unchanged. Vendor Review: NA. (ky)
5/1/25	2/18/25		Routine maintenance. Policy statement unchanged. Vendor Review: NA. (ky)

Next Review Date: 1st Qtr. 2026

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN:	Revised:
BCBSM:	Revised:

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: DRY NEEDLING OF TRIGGER POINTS FOR MYOFASCIAL PAIN

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Not covered
BCNA (Medicare Advantage)	See government section
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.
- Duplicate (back-up) equipment is not a covered benefit.