Dry Needling
Corporate Medical Policy

File name: Dry Needling
File code: UM.REHAB.09
Origination: 04/2015
Last Review: New policy
Next Review: 04/2016
Effective Date: 9/1/2015

Description
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. **Dry needling** of a trigger point is a technique for pain treatment in which the pain site is stimulated by insertion of a needle without injection of medication. The needle is used to systematically tap and percutaneously jab the trigger point to instill mild bleeding. This is thought to reset the inflammatory response and allow fibroblastic proliferation and collagen formation leading to tendon healing.

Dry needling is also known as trigger point dry needling, or intramuscular needling.

Policy Guidelines
Dry needling is considered **Experimental/Investigational** for any condition.

Coding Information
**Attachment I- CPT Coding Table & Instructions**

There is no specific CPT code for dry needling; therefore CPT code 97799 (Unlisted physical medicine/rehabilitation service or procedure) is the appropriate CPT code to use for billing purposes.

BCBSVT does not consider dry needling to be a manual therapy and should not be billed with CPT code 97140 (Manual therapy techniques, (eg, mobilization/manipulation, manual lymph drainage, manual traction, one or more regions, each 15 minutes).
BCBSVT does not consider dry needling to be an injection and should not be billed with CPT code 20552 (Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s) or CPT 20553 (single or multiple trigger point(s), 3 or more muscles.

**Rationale**

**Scientific Background**

Dry Needling: A 2013 systematic review and meta-analysis by Kietrys et al evaluated the effectiveness of dry needling for reducing pain in patients with myofascial pain syndrome of the upper quarter. Meta-analyses included: dry needling compared to sham or control, immediate effects; dry needling compared to sham or control, four weeks; dry needling compared to other treatments, immediate effects; dry needling compared to other treatments, four weeks. Results of the evaluations found three studies showed evidence dry needling produced immediate effect in decreasing pain in patients with upper quarter myofascial pain syndrome. Other studies had mixed results when compared to sham or control at four weeks. Two studies also showed lidocaine injection may be more effective in reducing pain than dry needling at four weeks. The authors noted further well-designed studies are needed to further explore the effect of the treatment.

Stenhouse et al (2013) compared dry needling along versus dry needling and PRP. Twenty-eight patients were randomized to either procedure and status was checked at two months and six months following the procedures. At two months follow up, there was no statistically significant difference in VAS improvement between the two groups.

A 2011 Cochrane Review was done by Furlan to assess the effects of acupuncture and dry needling for the treatment of nonspecific low back pain. The review included 23 clinical trials. Furlan concluded that the data do not allow firm conclusions regarding effectiveness of acupuncture for low back pain. While the data suggested acupuncture and dry needling may be useful adjuncts to other therapies, most of the studies were of lower methodologic quality, and there is a clear need for higher quality studies in this area.

There is little evidence to support dry needling. A Cochrane assessment of dry needling for lower back pain found that while dry needling may be a useful adjunct to other therapies, most of the limited number of studies available were of low methodological quality and small sample size (Furlan, 2000).

A review by Kalichman and Vulfsons (2010) looked at studies evaluating dry needling for musculoskeletal pain. The researchers found it to be an effective, minimally invasive treatment for chronic musculoskeletal pain.

A 2010 review by Cotchett et al. looked at the effectiveness of dry needling and injections for myofascial trigger points associated with plantar heel pain. They found limited evidence supporting the effectiveness of the treatment. Studies were of poor quality and heterogeneous. RCTs are needed to better measure results.
Tough et al (2009) reviewed literature on needling without injection and found there is limited evidence that deep needling directly into myofascial trigger points has an overall treatment effect when compared with standardized care. Stenhouse et al (2013) compared dry needling along versus dry needling and PRP. Twenty-eight patients were randomized to either procedure and status was checked at two months and six months following the procedures. At two months follow up, there was no statistically significant difference in VAS improvement between the two groups.

In 2009, Tough and colleagues published a systematic review and meta-analysis of randomized controlled trials addressing dry needling in the management of myofascial trigger point pain. A meta-analysis was performed on four studies of 134 participants that included a placebo control. This analysis concluded that dry needling was not superior to placebo. Other randomized studies reported conflicting findings. The authors concluded the limited sample size and poor quality of these studies highlights and supports the need for large scale, good quality placebo controlled trials in this area.

Reference Resources

Document Precedence
Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between
medical policy and contract language, the member’s contract language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP plan brochure.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through a self-funded (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s plan documents or contact the customer service department.

Policy Implementation/Update information

4/2015 New Policy

Approved by BCBSVT Medical Directors Date Approved

Joshua Plavin, MD
Senior Medical Director
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer
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