

1 **Clinical Practice Guideline: Lower Extremity Trigger Point Injections**

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3 **Date of Implementation: December 18, 2015**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers services consisting of CPT Codes  
10 20552 and 20553 to be medically necessary for the treatment of myofascial pain syndrome  
11 (see diagnoses in table below) with a local anesthetic, with or without steroid, when the  
12 following indications are met:

- 13 1. The patient’s medical record must contain documentation that fully supports the  
14 medical necessity for trigger point injections as opposed to alternate forms of  
15 therapy; and
- 16 2. Patient has local pain symptoms that have persisted for more than 3 months causing  
17 tenderness and/or weakness, restricting motion and/or causing referred pain when  
18 compressed; and
- 19 3. A taut band is palpable in an accessible muscle with exquisite tenderness at one  
20 point along its length; and
- 21 4. Patient has been unsuccessful with  $\geq 6$  weeks or intolerant of non-operative  
22 therapies:
  - 23 o Activity modification
  - 24 o Physical therapy/chiropractic
  - 25 o Oral medication; and
- 26 5. The trigger point injections are being given as part of an overall management  
27 (usually short term) plan including other types of therapy (e.g., physical therapy,  
28 occupational therapy).

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30 The above specific criteria must also be associated with **at least ONE of the following**  
31 **MINOR CRITERIA:**

- 32 • Reproduction of clinical pain complaint or altered sensation by pressure on the  
33 tender spot; or
- 34 • Local response (twitch) elicited by snapping palpation at the tender spot or by  
35 needle insertion into the tender spot; or
- 36 • Pain alleviation by elongating (stretching) the muscle or by injecting the tender  
37 spot.

1 The following schedule for trigger point injections is considered medically necessary when  
 2 the previous criteria are met:

- 3 • In the diagnostic or stabilization phase, individuals may receive injections at  
 4 intervals of no sooner than two weeks. The number of trigger point injections  
 5 should be limited to no more than 4 times per year for the diagnostic and/or  
 6 stabilization phase.
- 7 • In the treatment or therapeutic phase, trigger point injections should continue only  
 8 if the previous diagnostic injections provided pain relief and the frequency should  
 9 include an interval of 2 months or longer between each injection. The previous  
 10 injections should have provided at least greater than 50% relief of pain for a period  
 11 of at least 6 weeks and this should be documented in the medical record. Continued  
 12 injections are based on the medical necessity criteria above and these will be limited  
 13 to a maximum of 4 times per year for local anesthetic and steroid injections.
- 14 • Regardless of the number of injections administered to sites or regions on a  
 15 particular day, only one service (CPT® 20552 or 20553) is medically necessary.
- 16 • If a patient requires more than 4 sets/series of injections during one year, (trigger  
 17 points in different anatomical locations), a report stating the unusual circumstances  
 18 and medical necessity for giving the additional injections must accompany the  
 19 request for review and individual consideration.

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 21 Standard medical practice dictates that responsiveness to prior trigger point injections with  
 22 improvement in pain and functional status must have occurred before repeat injections are  
 23 medically necessary, e.g., a greater than 50% pain relief is obtained for 6 weeks. Injections  
 24 should not be used in isolation as sole method of treatment. They should facilitate  
 25 mobilization by providing pain relief and assist in application of non-invasive modalities,  
 26 e.g., physical therapy, medications, and other alternate therapies that address muscle  
 27 strengthening, flexibility, and functional restoration. All of this information must be  
 28 documented thoroughly in the medical record.

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 30 The use of corticosteroid injections is *always* subject to medical necessity review.

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 32 If the above criteria are not met, this service is considered not medically necessary.

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 34 **ICD-10 Codes and Descriptions That Support Medical Necessity (if criteria are met):**

ICD-10 Code	ICD-10 Code Description
M60.80, M60.851 - M60.879, M60.88 - M60.89, M60.9	Myositis, thigh, lower leg, ankle and foot, unspecified site, other sites, and multiple sites
M62.40, M62.451 - M62.479, M62.48 - M62.49	Contracture of muscle of thigh, lower leg, ankle and foot, unspecified site, other sites, and multiple sites

ICD-10 Code	ICD-10 Code Description
M62.831, M62.838	Muscle spasm of calf - Other muscle spasm
M72.9	Fibroblastic disorder, unspecified
M76.60 - M76.62	Achilles tendinitis
M76.70 - M76.72	Peroneal tendinitis
M76.811 - M76.819	Anterior tibial syndrome
M76.821 - M76.829	Posterior tibial tendinitis
M77.50 - M77.52	Other enthesopathy of foot and ankle
M79.0	Rheumatism, unspecified
M79.10, M79.18	Myalgia, unspecified site or other sites
M79.604 - M79.609, M79.651 - M79.676	Pain in unspecified limb, thigh, leg, foot, and toes
M79.7	Fibromyalgia

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**CPT® Codes and Descriptions**

CPT® Code	CPT® Code Description
20552	Injections(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

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**DESCRIPTION/BACKGROUND**

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Myofascial trigger points (MTrPs) are defined as “hyperirritable spots in skeletal muscle associated with hypersensitive palpable nodules in a taut band” (Simons et al., 1998).

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These are characteristic of myofascial pain syndrome (MPS). Findings suggest that MPS

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is a complex form of neuromuscular dysfunction consisting of both motor and sensory

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abnormalities involving both the peripheral and central nervous systems (Shah and

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Gilliams, 2008). MTrPs are painful upon compression and can give a characteristic pain

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referral pattern. They can also give rise to referred tenderness, autonomic responses,

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motion restriction, and motor dysfunction. More specifically, trigger points are classified

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into active and latent trigger points. An “active” trigger point refers pain at rest, upon direct

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palpation, and with activity. On the other hand, “latent” trigger points are also painful upon

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compression but do not give off the characteristic referral pattern for the specific muscle

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while at rest. Identification of MTrPs by palpation (flat or pincer technique) includes the

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following features:

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- Identification of a taut muscle band containing a discrete palpable nodule

- 1 • Focal tenderness
- 2 • Spontaneous exclamation of pain by the patient (e.g., “jump sign”, whole body
- 3 movement) in response to digital pressure or dry needling
- 4 • Consistent and reproducible pattern of referred pain
- 5 • A local twitch response [LTR (muscle fasciculation)] by snapping or palpation

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7 Referred pain, LTR and EMG demonstration are not essential for clinical diagnosis but can  
8 be considered confirmatory observations (Dommerholt and Huijbregts, 2011).

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10 MTrPs are thought to form due to acute trauma or repetitive microtrauma, lack of exercise,  
11 nutritional deficiencies, postural faults, joint problems with dysfunctional movement  
12 patterns, proximal nerve compression and muscle spasm, muscle overload, and emotional  
13 stress (Shah et al., 2008; Simons et al., 1998; Dommerholt and Huijbregts, 2011). There is  
14 no laboratory or imaging test for establishing the diagnosis of trigger points; it depends  
15 therefore upon the detailed history and thorough examination.

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17 Trigger point injections are used to alleviate this pain. The goal is to identify and treat the  
18 cause of the pain, not just the symptoms. After making the diagnosis of myofascial pain  
19 syndrome and identifying the trigger point(s) responsible for it, various treatment options  
20 are available. Activity modification and physical therapy should be the first line of care.  
21 Passive and active physical therapy modalities should be implemented, including "stretch  
22 and spray" cold therapy, range of motion and deep soft tissue mobilization exercise  
23 therapy, and physical conditioning. Application of low intensity ultrasound directed at the  
24 trigger point may be helpful when the trigger point is otherwise inaccessible. Medical  
25 management may include consultation with a specialist in pain medicine or the use of  
26 analgesics and adjunctive medications, including anti-depressant medications, shown to be  
27 effective in the management of chronic pain conditions. If non-operative treatments fail or  
28 are not possible, trigger point injection of local anesthetic, with or without corticosteroid,  
29 into the muscle trigger points can be an effective modality for inactivating trigger points  
30 and providing relief of symptoms. Although not supported by rigorous randomized  
31 controlled trials (Cummings 2001), trigger point injections with a local anesthetic, with or  
32 without a steroid, are considered an accepted therapy for pain associated with myofascial  
33 pain syndrome or fibromyalgia. Ahmed et al. (2019) compared the effectiveness of local  
34 anesthetics and (botulinum-toxin A) BTX-A on pain intensity in patients with myofascial  
35 pain. In total, 33 studies were included. The meta-analyses revealed that local anesthetic  
36 injections were more effective than BTX-A at mitigating pain intensity. Multiple injection  
37 sessions of local anesthetics were more beneficial than a single session. Authors concluded  
38 that additional studies are needed to determine sources of heterogeneity mediating the  
39 observed differences in effectiveness of local anesthetic and BTX-A injections among the  
40 studies. Additional replicative studies are also needed to delineate the relative efficacy and  
41 effectiveness of local anesthetic and BTX-A injection. The quantitative results of this study  
42 suggest that patients overall experience more pain relief with local anesthetic injections.

1 In order to establish trigger points, the practitioner should identify the muscle or muscles  
2 where the trigger point(s) is/are located and document that in the patient's medical record.

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4 Use of injections should be done as part of an overall management (usually short term)  
5 plan including one or more of the following:

- 6 1. Diagnostic evaluation to clearly identify the primary cause, if possible
- 7 2. Physical and occupational therapy
- 8 3. Psychiatric evaluation and therapy
- 9 4. A trial of oral non-steroid analgesic/anti-inflammatory drugs, if not contraindicated

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11 Shipton et al. (2023) summarized trigger point management in an American Family  
12 Physician article. Trigger points producing myofascial pain syndromes are common in  
13 primary care. Some evidence from clinical trials supports massage, physical therapy, and  
14 osteopathic manual medicine as first-line less invasive treatment strategies. Trigger points  
15 are often treated with injections; although randomized trials have found statistically  
16 significant results with trigger point injections, conclusions are limited by low numbers of  
17 study participants, difficulty in blinding, the potential for a placebo effect, and lack of  
18 posttreatment follow-up. No single pharmacologic agent used in trigger point injections  
19 has been proven superior to another, nor has any single agent been proven superior to  
20 placebo. Trigger point injections, therefore, should be reserved for patients whose  
21 myofascial pain has been refractory to other measures, and family physicians should first  
22 employ less invasive treatment strategies. Trigger point management is only one part of a  
23 comprehensive, multimodal, and team-based approach to patients with myofascial pain.

## 24 **PRACTITIONER SCOPE AND TRAINING**

25  
26 Practitioners should practice only in the areas in which they are competent based on their  
27 education, training, and experience. Levels of education, experience, and proficiency may  
28 vary among individual practitioners. It is ethically and legally incumbent on a practitioner  
29 to determine where they have the knowledge and skills necessary to perform such services  
30 and whether the services are within their scope of practice.

31  
32 It is best practice for the practitioner to appropriately render services to a member only if  
33 they are trained, equally skilled, and adequately competent to deliver a service compared  
34 to others trained to perform the same procedure. If the service would be most competently  
35 delivered by another health care practitioner who has more skill and training, it would be  
36 best practice to refer the member to the more expert practitioner.

1 Best practice can be defined as a clinical, scientific, or professional technique, method, or  
 2 process that is typically evidence-based and consensus driven and is recognized by a  
 3 majority of professionals in a particular field as more effective at delivering a particular  
 4 outcome than any other practice (Joint Commission International Accreditation Standards  
 5 for Hospitals, 2020).

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 7 Depending on the practitioner’s scope of practice, training, and experience, a member’s  
 8 condition and/or symptoms during examination or the course of treatment may indicate the  
 9 need for referral to another practitioner or even emergency care. In such cases it is prudent  
 10 for the practitioner to refer the member for appropriate co-management (e.g., to their  
 11 primary care physician) or if immediate emergency care is warranted, to contact 911 as  
 12 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for  
 13 information.

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