Local Coverage Determination (LCD) for Trigger Point Injections (L28310)

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LCD Information

Document Information

LCD ID Number
L28310

LCD Title
Trigger Point Injections

Contractor's Determination Number
J1B-08-0082-L

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Oversight Region
Region X

Original Determination Effective Date
For services performed on or after 09/02/2008

Original Determination Ending Date

Revision Effective Date
For services performed on or after 10/13/2011

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Revision Ending Date

CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Indications and Limitations of Coverage and/or Medical Necessity

Myofascial trigger points are "small, circumscribed, hyperirritable foci in muscles and fascia, often found with a firm or taut band of skeletal muscle." (See Item 2 under "Sources of Information and Basis for Decision.") These trigger points produce a referred pain patterned characteristic for that individual muscle. Each pattern becomes a single part of a single muscle syndrome. To successfully treat chronic myofascial pain syndrome (trigger points) each single muscle syndrome needs to be identified along with every perpetuating factor.

The pain of active trigger points can begin as an acute single muscle syndrome resulting from stress overload or injury to the muscle, or can develop slowly because of chronic or repetitive muscle strain. The pain normally refers distal to the specific hypersensitive trigger point. Trigger point injections are used to alleviate this pain.

There is no laboratory or imaging test for establishing the diagnosis of trigger points; it depends therefore upon the detailed history and thorough examination. The following diagnostic criteria are adopted by this A/B MAC from Simons. (See Item 3 under Sources of Information and Basis for Decision.)

Major criteria. All four must be present to establish the diagnosis.

A. Regional pain complaint
B. Pain complaint or altered sensation in the expected distribution of referred pain from a trigger point
C. Taut band palpable in an accessible muscle with exquisite tenderness at one point along the length of it
D. Some degree of restricted range of motion, when measurable.

Minor criteria. Only one of four needed for the diagnosis.

A. Reproduction of referred pain pattern by stimulating the trigger point
B. Altered sensation by pressure on the tender spot
C. Local response elicited by snapping palpation at the tender spot or by needle insertion into the tender spot
D. Pain alleviated by stretching or injecting the tender Spot

The goal is to identify and treat the cause of the pain, not just the symptom. After making the diagnosis of myofascial pain syndrome and identifying the trigger point responsible for it, the treatment options are:

1. Medical management, which may include consultation with a specialist in pain medicine
2. Medical management that may include the use of analgesics and adjunctive medications, including anti-depressant medications, shown to be effective in the management of chronic pain conditions.
3. Passive physical therapy modalities, including "stretch and spray" heat and cold therapy, passive range of motion and deep muscle massage.
4. Active physical therapy, including active range of motion, exercise therapy and physical conditioning. Application of low intensity ultrasound directed at the trigger point (this approach is used when the trigger point is otherwise inaccessible).
5. Manipulation therapy.
6. Injection of local anesthetic, with or without corticosteroid, into the muscle trigger points.

a. as initial or the only therapy when a joint movement is impaired, such as when a muscle cannot be stretched fully or is in fixed position.

b. as treatment of trigger points that are unresponsive to non-invasive methods of treatment, e.g., exercise, use of medications, stretch and spray.

The CPT codes for trigger point injections use the phrase "muscle group(s)". For the purpose of this policy, this A/B MAC defines "muscle group" as a group of muscles that are contiguous and that share a common function, e.g., flexion, stabilization or extension of a joint. Trigger points that exist in muscles that are widely separated anatomically and that have different functions may be considered to be in separate muscle groups.

To treat established trigger points, after identification of the muscle or muscle group where the trigger point is located and documenting that in the patient's medical record.

Coverage is provided for injections which are medically necessary due to illness or injury and based on symptoms and signs. An injection of a trigger point is considered medically necessary when it is currently causing tenderness and/or weakness, restricting motion and/or causing referred pain when compressed.

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

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

Acupuncture is not a covered service, even if provided for treatment of an established trigger point.

Use of acupuncture needles and/or the passage of electrical current through these needles is not a covered service, whether the service is rendered by an acupuncturist or any other provider.

Providers of acupuncture services must inform the beneficiary that their services will not be covered as acupuncture is not a Medicare benefit.

Prolotherapy, the injection into a damaged tissue of an irritant to induce inflammation, is not covered by Medicare. Billing this under the trigger point injection codes is misrepresentation.

"Dry needling" of trigger points is a non-covered procedure since it is considered unproven and investigational.

Screening diagnoses will be denied as routine services.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

999x	Not Applicable

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999	Not Applicable

CPT/HCPCS Codes

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 MUSCLE(S)

ICD-9 Codes that Support Medical Necessity

These are the **only** covered ICD-9-CM codes that support medical necessity:

This A/B MAC will assign the following three ICD-9-CM codes to indicate the diagnosis of a trigger point. Claims without one of these diagnoses will always be denied.

720.1	SPINAL ENTHESOPATHY
726.32	LATERAL EPICONDYLITIS

726.5	ENTHESOPATHY OF HIP REGION
726.71	ACHILLES BURSITIS OR TENDINITIS
726.72	TIBIALIS TENDINITIS
729.0	RHEUMATISM UNSPECIFIED AND FIBROSITIS
729.1	MYALGIA AND MYOSITIS UNSPECIFIED
729.4	FASCIITIS UNSPECIFIED

Diagnoses that Support Medical Necessity
All ICD-9-CM codes listed in this policy under ICD-9-CM Codes That Support Medical Necessity above.
ICD-9 Codes that DO NOT Support Medical Necessity
All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes That Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes That Support Medical Necessity above.

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General Information

Documentations Requirements
The patient's medical record must have:

1. Documentation of proper evaluation leading to diagnosis of the trigger point. This must include the patient's history, extenuating circumstances (i.e. level of pain, interruption of activities of daily living), specific diagnosis codes, drugs injected, dosage of the drug.

2. The specific site of each injection, including identification of the affected muscle(s).

3. Documentation of reasons for selecting this therapeutic option, including the medical necessity for giving the injection, and the expected outcome of the treatment.

4. Precise diagnosis code(s) must be used. Generalized diagnoses like low back pain, lumbago, etc., will not be covered.

5. Multiple trigger points may be injected during any session.

6. If a patient requires more than three sets of injections during one year, a report stating the unusual circumstances and medical necessity for giving the additional injections may be requested for review and individual consideration.

Documentation must reflect the medical necessity of providing the service. The major and minor criteria (listed above under Indications and Limitations of Coverage and/or Medical Necessity) must be documented in the medical record and the record must be made available to Medicare upon request. The need for repeated injections (see Utilization

Guidelines below) must be documented in the medical record.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

Appendices

Utilization Guidelines
This A/B MAC has adopted the following guidelines from Manchikanti et al (2).

1. In the diagnostic or stabilization phase, a patient may receive trigger point injections at intervals of no more frequently than every two weeks.

2. In the treatment or therapeutic phase (after stabilization is completed), the frequency should be two months or longer between each injection provided that at least >50% relief is obtained for six weeks.

3. In the diagnostic or stabilization phase, the number of trigger point injections should be limited to no more than four times per year.

4. In the treatment or therapeutic phase, the trigger point injections should be repeated only as reasonable and medically necessary, and these should be limited to a maximum of six times for local anesthetic and steroid injections.

5. Only one Trigger Point Injection CPT code can be billed per date of service.

6. Because the ICD-9-CM manual does not list "trigger point" or "myofascial pain syndrome," this LCD lists related diagnoses that can reasonably include trigger points and uses "myofascial pain syndrome" to refer to trigger points.

Sources of Information and Basis for Decision
1. Local Medical Review Policy from Iowa, Aug 1999

2. Manchikanti L, Singh V, Kloth D, et al. Interventional Techniques in the Management of Chronic Pain: Part 2.0. *Pain Physician.* 2001;4(1):24-96

3. Simons DG. Muscular Pain Syndromes. In: JR Friction. Awad EA, JR. eds. *Advances in Pain Research and Therapy.* Lippincott-Raven. Philadelphia. 1990;17:1-41.

4. Travell JG, Simons DG. *Myofascial Pain and Dysfunction, The Trigger Point Manual.* Baltimore. Lippincott Williams & Wilkins. 1983.

5. The following sources of information were cited in the Iowa LMRP:

● Other Carrier Policies (Kansas/Nebraska/Western Missouri, North Dakota, GHI of New York)
● Satterthwaite, Dollison. *Handbook of Pain Management.* Williams and Wilkins. 1994;2 ed.
● Yale University School of Medicine, Department of Pain Management
Connecticut Society of Anesthesiology

● Local Medical Policy from Nationwide Insurance Company
● Medicare Operations Spine Five: 1980;193-200.
● *Journal of Neurosurgery.* 1975;43:448-51.

Advisory Committee Meeting Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community.

Contractor Advisory Committee meeting dates:

California -
Hawaii -
Nevada -

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period
06/16/2008

Revision History Number
Revision #6

Revision History Explanation
Revision #6 effective for dates of service on or after 10/13/2011.
Revision made: Under Sources of Information and Basis for Decisions removed the statement “Other carriers’ LCDs,” as this statement does not include the names of the LCDs nor specifically whose LCDs were used to develop the LCD.

Revision #5, effective for dates of service on or after 10/21/2010
Revisions made: Under Sources of Information and Basis for Decisions added additional authors' and completed publication sources.

Revision #4, 02/26/2009
This LCD is being revised to implement the streamlining of the Part B LCDs per the published article “Palmetto Team to Streamline Part B LCDs in Jurisdiction 1 (J1).” This article can be viewed at www.PalmettoGBA.com by searching for the above article name. This revision will become effective on 02/26/2009.

Revision #3, effective for dates of service on or after 01/01/2009
Revision made: Annual 2009 CPT/ HCPCS update; "CPT/HCPCS Codes" revised CPT codes 20552 and 20553 descriptors were revised.

Revision #2, 10/30/2008
Revisions made: In the section "CMS National Coverage Policy" removed redundant verbiage. Added ICD-9 codes 720.1, 726.32, 726.5, 726.71, 726.72 to the "ICD-9 Codes that Support Medical Necessity" section for CPT codes 20552 and 20553. The "Documentation Requirements" had the SSA citation removed as it is referenced in the "CMS National Coverage Policy". Under “Sources of Information and Basis for Decision” references were placed in the AMA citation formation. Completed the annual validation of this LCD. This LCD will become effective on 10/30/2008.

Revision #1, 09/02/2008
This LCD is being revised to add Bill Type 999X because the automated system transcription process was incomplete.

11/09/2008 - The description for CPT/HCPCS code 20552 was changed in group 1
11/09/2008 - The description for CPT/HCPCS code 20553 was changed in group 1

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
20552 descriptor was changed in Group 1
20553 descriptor was changed in Group 1

Reason for Change
Maintenance (annual review with new changes, formatting, etc.)

Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.

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All Versions

Updated on 06/18/2012 with effective dates 10/13/2011 - N/A
Updated on 10/07/2011 with effective dates 10/13/2011 - N/A
Updated on 11/21/2010 with effective dates 10/21/2010 - 10/12/2011
Updated on 10/15/2010 with effective dates 10/21/2010 - N/A
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

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