

2.01.100	Dry Needling of Myofascial Trigger Points		
Original Policy Date:	July 1, 2016	Effective Date:	March 1, 2020
Section:	2.0 Medicine	Page:	Page 1 of 9

Policy Statement

Dry needling of trigger points for the treatment of myofascial pain is considered **investigational**.

Policy Guidelines

Coding

Effective January 1, 2020, there are new CPT codes that represent dry needling or trigger point acupuncture:

- **20560:** Needle insertion(s) without injection(s); 1 or 2 muscle(s)
- **20561:** Needle insertion(s) without injection(s); 3 or more muscles

CPT instructs that the following unlisted code may be used for the dry needling procedure:

- **20999:** Unlisted procedure, musculoskeletal system, general

Because dry needling is not acupuncture, CPT codes 97810-97814 are not appropriate.

Description

Trigger points are discrete, focal, hyperirritable spots within a taut band of skeletal muscle fibers that produce local and/or referred pain when stimulated. 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.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. 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.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

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

Rationale

Background

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

Literature Review

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

Clinical Context and Therapy Purpose

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

The question addressed in this evidence review is: does dry needling improve the net health outcome in patients with myofascial pain?

The following PICOTS were used to select literature to inform this review.

Patients

The relevant populations of interest are individuals with myofascial trigger points associated with neck, shoulder, plantar heel, or temporomandibular myofascial 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.

Neck and/or Shoulder Pain

A qualitative systematic review by Cagnie et al (2015) included 8 studies published through 2013 that met selection criteria for deep dry needling of trigger points of the upper trapezius in patients with neck pain.³ Only studies rated as moderate or good quality were included. Outcomes for the short- and medium-term were assessed for pain, range of motion (ROM), functionality, and QOL. Control treatments included lidocaine injection plus self-stretching, non-trigger point deep needling, mini-scalpel needling, sham acupuncture, and superficial dry needling. All studies showed a decrease in pain with dry needling but only one study found a greater reduction in pain with dry needling than with other treatments. Reviewers found moderate evidence that dry needling, ROM exercises, and lidocaine injections increased ROM. One study found an improvement in QOL comparable to that of nonsteroidal anti-inflammatory medications and, of three studies that assessed depression, which was used as a proxy for QOL, only one found significant improvement after treatment with deep dry needling.

Several RCTs have been published since the Cagnie (2015) review.^{4,5,6,7,8} As noted above, the review focused on trials comparing dry needling with sham or manual therapy. None of the new RCTs was sham-controlled; two compared dry needling with manual therapy and are described next.

An RCT by Llamas-Ramos et al (2014) compared trigger point dry needling with trigger point manual therapy in 94 patients.⁴ Patients had mechanical neck pain, defined as “neck and shoulder pain with symptoms provoked by neck postures, neck movement, or palpation of the cervical muscles.” Strengths of this trial included allocation concealment, blinding, intention-to-treat analysis, and adequate power. Multivariate analyses did not find statistically significant differences between groups in neck pain or disability scores. However, patients in both groups had similar decreases in pain intensity and disability. For example, pain intensity was 6.2 at baseline for both groups; it decreased to near two points immediately postintervention and near one at two-week follow-up. Cervical ROM was also improved to a similar extent in both groups, while pain pressure threshold was significantly better for the dry needling group. Temporary muscle soreness or fatigue was reported by 55% of the dry needling group and by 23% of the manual therapy group.

In another RCT, De Meulemeester et al (2017) assessed 42 patients with myofascial neck and/or shoulder pain.⁵ Patients were assigned to 4 sessions of dry needling (n=20) or manual pressure (n=22). The primary outcome was disability assessed using a 50-point Neck Disability Index. Baseline Neck Disability Index score was at least ten in all patients. Patients were evaluated at the end of the intervention period and again after three months. There were no significant differences in Neck Disability Index scores between the dry needling group and the manual pressure group at either follow-up point ($p>0.05$). Also, findings were not significantly better in the dry needling group than with the manual pressure group for secondary outcomes, including the pressure pain threshold and pain intensity (measured on a numeric rating scale).

Section Summary: Neck and/or Shoulder Pain

A number of RCTs have evaluated dry needling of myofascial trigger points for neck and/or shoulder pain, and there is a systematic review of RCTs published through 2013. As reported in a systematic review, only one of eight studies found significantly greater reductions in pain with dry needling than with other treatments. Two more recent RCTs comparing dry needling with manual therapy did not find significantly better outcomes after dry needling.

Plantar Heel Pain

Cotchett et al (2010) reported on a systematic review of dry needling and injections of myofascial trigger points associated with plantar heel pain.⁹ Three quasi-experimental trials were identified: two evaluated dry needling plus acupuncture and a third evaluated lidocaine injections plus physical therapy. The methodologic quality of the trials was rated as poor and meta-analysis was not conducted due to heterogeneity among trials.

Two RCTs, both published after the systematic review, are described next. Cotchett et al (2014) reported on a double-blind, sham-controlled randomized trial of trigger point dry needling for plantar heel pain.¹⁰ Patients (n=84) with plantar heel pain for at least 1 month in duration were assigned to 6 weekly active or sham treatments. The primary outcomes (first step heel pain and Foot Health Status Questionnaire scores at 6 weeks) were measured in 81 (96.4%) patients. The group given dry needling had statistically significant greater reduction in first step pain and foot pain (adjusted mean difference, 14.4 mm on a 100-mm visual analog scale [VAS] and 10.0 points on the Foot Health Status Questionnaire) but the magnitude of change did not meet the prespecified minimally important difference for the scales used. Seventy (32% of treatments) minor adverse events were reported in the active dry needling group compared with only 1 (<1%) in the sham group. The number needed to harm was three. Strengths of this trial included allocation concealment, patient and evaluator blinding, sample size calculations for adequate power, and a high rate of follow-up. Limitations included the lack of reporting response rates (i.e., the percentage of patients who experienced improvement on the primary outcome measures that was equal to or greater than the prespecified minimally important difference).

Eftekharsadat et al (2016) published a single-blinded RCT evaluating 20 patients with plantar fasciitis in Iran.¹¹ Patients with plantar heel pain for at least one month in duration were assigned to treatment with dry needling (n=10) or usual care (n=10). The intervention group received one

dry needling session of myofascial trigger points per week for four weeks. Also, all patients were instructed in stretching exercises and were administered anti-inflammatory medication. The primary outcomes- pain on a 100-point VAS, and ROM of the ankle joint in dorsiflexion and plantar extension- were measured at baseline, at the end of the intervention period, and 4 weeks after the intervention ended. All patients completed the trial. At the end of the intervention, the mean VAS score was significantly lower in the treatment group (2.6) than in the usual care group (6.6; $p < 0.001$). However, 4 weeks after the intervention had ended, there was no statistically significant difference in VAS scores between groups (mean VAS scores, 3.0 vs 3.5; $p = 0.36$, respectively). Moreover, there was no significant between-group difference in ROM of the ankle joint in dorsiflexion and plantar extension scores at the end of the intervention or at four weeks postintervention. Adverse events were not reported.

Section Summary: Plantar Heel Pain

The evidence base consists of a systematic review of quasi-experimental studies and two RCTs. The systematic review rated the quality of the studies it assessed as poor. One randomized trial was double-blind and sham-controlled; it found a statistically significantly greater reduction in pain in the dry needling group compared with sham but the difference was not clinically significant (i.e., did not reach the prespecified minimally important difference). The other, a single-blind trial comparing dry needling with usual care, found significantly greater reductions in pain at the end of active treatment but not at the follow-up one month later. Moreover, ROM outcomes did not differ significantly between groups at either time point. To date, research has not demonstrated a statistical and clinical benefit of dry needling. Additional RCTs, especially those with a sham-control group, would strengthen the evidence base.

Temporomandibular Myofascial Pain

A double-blind, sham-controlled trial of dry needling for the treatment of temporomandibular myofascial pain was reported by Diracoglu et al (2012).¹² 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 ($p = 0.478$). 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; $p = 0.411$). The mean pain pressure threshold was significantly higher in the treatment group (3.21 kg/cm²) than in the control group (2.75 kg/cm²; $p < 0.001$).

Section Summary: Temporomandibular Myofascial Pain

One RCT evaluating dry needling for the treatment of temporomandibular myofascial pain was identified; this 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 single 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.

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.¹³

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 RCTs and a systematic review. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. As reported in the systematic review of literature published through 2013, only 1 of 8

studies found significantly greater reductions in pain with dry needling compared with other treatments. Two more recent RCTs comparing dry needling with manual therapy did not find significantly better outcomes after dry needling. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have myofascial trigger points associated with plantar heel pain who receive dry needling of trigger points, the evidence includes RCTs, quasi-experimental studies, and a systematic review. The relevant outcomes are symptoms, functional outcomes, QOL, and treatment-related morbidity. The systematic review, which included three quasi-experimental studies, rated study quality as poor. One RCT was double-blind and sham-controlled; it found a statistically significant greater reduction in pain in the dry needling group than in the sham group but the difference was not clinically significant (i.e., it did not meet the prespecified minimally important difference). The other RCT, a single-blind trial comparing dry needling with usual care, found a significantly greater reduction in pain at the end of active treatment but not at follow-up one month later. Moreover, ROM outcomes did not differ significantly between groups at either time point. To date, the studies have not demonstrated a statistical or a clinical benefit for dry needling. Additional RCTs, especially those with a sham-control group, would strengthen the evidence base. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have myofascial trigger points associated with temporomandibular myofascial pain who receive dry needling of trigger points, the evidence includes an RCT. 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. Additional RCTs, especially those with a sham-control group, are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information Practice Guidelines and Position Statements

American Physical Therapy Association

A educational resource paper by the American Physical Therapy Association (2012) defined dry needling as "a skilled intervention used by physical therapists (where allowed by state law) that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments."¹⁴

The Association (2013) issued an educational resource paper that included the following indications for dry needling: radiculopathies, joint dysfunction, disc pathology, tendonitis, craniomandibular dysfunction, carpal tunnel syndrome, whiplash-associated disorders, and complex regional pain syndrome.¹

American Academy of Orthopaedic 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."

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT02532595	Trigger Point Dry Needling, Manual Therapy and Exercise vs Manual Therapy and Exercise For the Management of Achilles Tendinopathy	66	Dec 2018
NCT02373644	Spinal Manipulation and Dry Needling Versus Conventional Physical Therapy in Patients With Sacroiliac Dysfunction: a Multi-center Randomized Clinical Trial	95	March 2019
Unpublished			
NCT02373631	Dry Needling Versus Conventional Physical Therapy in Patients With Knee Osteoarthritis: a Multi-center Randomized Clinical Trial	105	May 2017
NCT02373618	Dry Needling Versus Conventional Physical Therapy in Patients With Plantar Fasciitis: a Multi-center Randomized Clinical Trial	108	May 2017
NCT02312895	Randomized Controlled Trial Comparing the Use of Dry Needling to Manual Therapy for Patients With Mechanical Low Back Pain	73	Aug 2018

NCT: national clinical trial.

References

1. American Physical Therapy Association (APTA). Educational resource paper: Description of Dry Needling in Clinical Practice. 2013; <http://www.apta.org/StateIssues/DryNeedling/ClinicalPracticeResourcePaper/>. Accessed March 13, 2019.
2. Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. *Am Fam Physician*. Feb 15 2002;65(4):653-660. PMID 11871683.
3. Cagnie B, Castelein B, Pollie F, et al. Evidence for the use of ischemic compression and dry needling in the management of trigger points of the upper trapezius in patients with neck pain: a systematic review. *Am J Phys Med Rehabil*. Jul 2015;94(7):573-583. PMID 25768071.
4. Llamas-Ramos R, Pecos-Martin D, Gallego-Izquierdo T, et al. Comparison of the short-term outcomes between trigger point dry needling and trigger point manual therapy for the management of chronic mechanical neck pain: a randomized clinical trial. *J Orthop Sports Phys Ther*. Nov 2014;44(11):852-861. PMID 25269764.
5. De Meulemeester KE, Castelein B, Coppieters I, et al. Comparing trigger point dry needling and manual pressure technique for the management of myofascial neck/shoulder pain: a randomized clinical trial. *J Manipulative Physiol Ther*. Jan 2017;40(1):11-20. PMID 28017188.
6. Perez-Palomares S, Olivan-Blazquez B, Perez-Palomares A, et al. Contribution of dry needling to individualized physical therapy treatment of shoulder pain: a randomized clinical trial. *J Orthop Sports Phys Ther*. Jan 2017;47(1):11-20. PMID 27937046.
7. Cerezo-Tellez E, Lacomba MT, Fuentes-Gallardo I, et al. Dry needling of the trapezius muscle in office workers with neck pain: a randomized clinical trial. *J Man Manip Ther*. Sep 2016;24(4):223-232. PMID 27582622.
8. Cerezo-Tellez E, Torres-Lacomba M, Fuentes-Gallardo I, et al. Effectiveness of dry needling for chronic nonspecific neck pain: a randomized, single-blinded, clinical trial. *Pain*. Sep 2016;157(9):1905-1917. PMID 27537209.

9. Cotchett MP, Landorf KB, Munteanu SE. Effectiveness of dry needling and injections of myofascial trigger points associated with plantar heel pain: a systematic review. *J Foot Ankle Res.* Sep 1 2010;3:18. PMID 20807448.
10. 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):1083-1094. PMID 24700136.
11. 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.* Sep 2016;30:401. PMID 27683642.
12. 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.* Dec 2012;25(4):285-290. PMID 23220812.
13. 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):134-140. PMID 25125935.
14. American Physical Therapy Association (APTA). Physical Therapists and the Performance of Dry Needling. 2012; <http://www.apta.org/Statelssues/DryNeedling/ResourcePaper/>. Accessed March 13, 2019.
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 March 13, 2019.
16. Blue Cross Blue Shield Association. Medical Policy Reference Manual, No. 2.01.100 (April 2019).

Documentation for Clinical Review

- No records required

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

IE

The following services may be considered investigational.

Type	Code	Description
CPT®	20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s) (Code effective 1/1/2020)
	20561	Needle insertion(s) without injection(s); 3 or more muscles (Code effective 1/1/2020)
	20999	Unlisted procedure, musculoskeletal system, general
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
07/01/2016	BCBSA Medical Policy Adoption

Effective Date	Action
06/01/2017	Policy revision without position change
06/01/2018	Policy revision without position change
06/01/2019	Policy revision without position change
03/01/2020	Coding update

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.