

2.01.100	Dry Needling of Myofascial Trigger Points		
Original Policy Date:	July 1, 2016	Effective Date:	July 1, 2023
Section:	2.0 Medicine	Page:	Page 1 of 12

Policy Statement

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

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Coding

There are 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

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, 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, 2 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.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Dry Needling of Myofascial 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 is individuals with myofascial trigger points associated with myofascial neck and/or 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, quality of life, and treatment-related morbidity.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Systematic 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 RCTs 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 of 28 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.⁶ 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; $I^2=0.00%$; $p<.02$; 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 to other physical therapy modalities.

Dry Needling of Myofascial Trigger Points Associated with Plantar Heel Pain

Clinical Context and Therapy Purpose

The purpose of dry needling in individuals who have plantar heel myofascial 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 is individuals with myofascial trigger points associated with plantar heel 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, quality of life, and treatment-related morbidity.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence**Systematic 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).⁷ 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) ⁷
Bagcier et al (2020) ⁸	●
Cotchett et al (2014) ⁹	●
Eftekharsadat et al (2016) ¹⁰	●
Rahbar et al (2018) ¹¹	●
Rastegar et al (2017) ¹²	●
Uygur et al (2019) ¹³	●

Table 2. Systematic Review Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Llurda-Almuzara	Inception-2020	6	Patients with heel pain receiving dry needling or	395 (10 to 49)	RCT	1 to 6 sessions (mean, 4 sessions)

Study	Dates	Trials	Participants	N (Range)	Design	Duration
et al (2021) ⁷			comparator (placebo, no intervention, or active comparator)			

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) ⁷				
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>P</i>	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 Clinical Context and Therapy Purpose

The purpose of dry needling in individuals who have temporomandibular myofascial 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 is individuals with myofascial trigger points associated with temporomandibular myofascial pain. Trigger points are discrete, 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, quality of life, and treatment-related morbidity.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Randomized Controlled Trial

A double-blind, sham-controlled trial of dry needling for the treatment of temporomandibular myofascial pain was reported by Diracoglu et al (2012).¹⁴ 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 3 weeks. The sham condition involved dry needling in areas away from the trigger points. Patients were evaluated 1 week after the last needling. At follow-up, there was no significant difference between groups in pain scores assessed by a 10-point visual analog scale. Mean visual analog scale 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/cm²) than in the control group (2.75 kg/cm²; $p<.001$).

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.¹⁵

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

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

In 2009, the American Academy of Orthopaedic Manual Physical Therapists issued a statement that dry needling fell within the scope of physical therapist practice.¹⁶ 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 4.

Table 4. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT04851067	Dry Needling Versus Manual Therapy in Patients With Mechanical Neck Pain: A Randomized Control Trial	75	Mar 2022
NCT04726683	Trigger Point Dry Needling vs Injection in Patients With Temporomandibular Disorders: A Randomized Placebo-controlled Trial	58	Sep 2023
NCT03844802	Effectiveness of Real or Placebo Dry Needling Combined With Therapeutic Exercise in Adults With Chronic Neck Pain	60	Dec 2022
NCT05624515	Efficacy of Dry Needling and Ischaemic Compression of the Scapula Angularis Muscle in Patients With Cervicalgia. Randomised Clinical Trial	80	Jan 2023
NCT05532098	Comparative Efficacy of Platelet Rich Plasma and Dry Needling in Management of Anterior Disc Displacement of Temporomandibular Joint	78	Mar 2023

NCT: national clinical trial.

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- 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
- 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

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9. 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
10. 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
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12. 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
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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.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
	20561	Needle insertion(s) without injection(s); 3 or more muscles
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
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
07/01/2023	Policy reactivated. Previously archived from 06/01/2020 to 06/30/2023.

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 and Feedback (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.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

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.

Appendix A

POLICY STATEMENT	
BEFORE	AFTER <i>Blue font: Verbiage Changes/Additions</i>
<p>Reactivated Policy</p> <p>Policy Statement: N/A :</p>	<p>Dry Needling of Myofascial Trigger Points 2.01.100</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Dry needling of trigger points for the treatment of myofascial pain is considered <i>investigational</i>.