**Policy Statement**

Trigger point injections with anesthetic and/or corticosteroid may be considered **medically necessary** for the treatment of myofascial pain syndrome when **all** of the following criteria have been met:

- Conservative therapy (e.g., physical therapy, active exercises, ultrasound, heating or cooling, massage, activity modification, or pharmacotherapy) for 6 weeks fails or is not feasible
- No more than 4 injections are given in a 12-month period
- There is a regional pain complaint in the expected distribution of referral pain from a trigger point
- There is restricted range of motion
- There is spot tenderness in a palpable taut band in a muscle
- Trigger point injections are provided as a component of a comprehensive therapy program

Trigger point and tender point injections are considered **investigational** for all other indications, including the following:

- Abdominal wall pain
- Complex regional pain syndrome
- Fibromyalgia.
- Treatment of myofascial pain syndrome not meeting the medical necessity criteria

Ultrasound and other imaging guidance of trigger point injections are considered **investigational**.

**Policy Guidelines**

**Coding**

Trigger point injections are reported with the following CPT 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 muscles

Imaging guidance for the injection would be reported with one of the following codes, depending on the modality used:

- **76942**: Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
- **77002**: Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)
- **77021**: Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

**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. Tender points also produce local pain when stimulated, but lack the taut band of tissue and hyperirritability when palpated. Injection of an anesthetic agent or botulinum toxin into trigger points and tender points is being evaluated for the management of a variety of pain syndromes.
Related Policies

- Dry Needling of Myofascial Trigger Points

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

Although medications used with invasive trigger point and tender point procedures are regulated by the U.S. Food and Drug Administration (FDA), trigger and tender point injections are procedures and, as such, are not subject to regulation by the FDA.

Rationale

Background

Trigger Points

Definition

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

Treatment

Trigger point injections with local anesthetic, saline, steroid, or botulinum toxin type A are a potential treatment for pain associated with trigger points. 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

Associated Disorders

Myofascial Pain Syndrome

Myofascial pain syndrome is a chronic regional pain disorder caused by the activation of at least 1 trigger point in muscles, tendons, or muscle fascia. It can cause local or referred pain, tightness, tenderness, stiffness and limitation of movement, muscle weakness, and often autonomic phenomena. The severity of symptoms and degree of functional impairment vary. Some individuals will have few trigger points with mild symptoms and no functional impairment, while others will have multiple satellite trigger points, widespread and severe pain, and major functional impairments. Conditions that can lead to myofascial pain syndrome include chronic repetitive minor muscle strain, poor posture, systemic disease, strain, sprain, enthesopathy, and arthritis. Management of chronic myofascial pain typically includes behavioral and pharmacologic approaches and physical therapy. Injection of a local anesthetic or botulinum toxin has also been reported.
Complex Regional Pain Syndrome
Complex regional pain syndrome (CRPS; previously called sympathetic dystrophy) refers to a chronic and disabling condition characterized by persistent pain that is disproportionate to the extent and duration of the primary injury and that is not restricted to the distribution of a specific peripheral nerve. CRPS occurs most commonly following wrist fracture, but may follow many other types of injury, even when the preceding injury is relatively minor. CRPS may also occur when there is no known injury. CRPS is classified into type I when a specific nerve lesion has not been identified and type II when there is an identifiable nerve lesion. The pain may consist of thermal or mechanical allodynia (pain that occurs from a stimulus that normally does not elicit a painful response such as light touch or warmth) dysesthesia (a constant or ongoing unpleasant or electrical sensation of pain), and/or hyperalgesia (an exaggerated response to normally painful stimuli). Management of CRPS includes oral and topical pharmacotherapy, physical therapy, psychological therapies, and interventional procedures such as regional anesthetic blocks, sympathetic blocks, or spinal cord stimulation. Amputation of the affected limb has also been performed.

Abdominal Wall Pain
A source of chronic abdominal wall pain is anterior cutaneous nerve entrapment syndrome, which typically presents as sharp and focal abdominal pain, and is often found near a scar. One hypothesis is that anterior cutaneous nerve entrapment syndrome results from the entrapment and ischemia of an anterior cutaneous branch of a thoracic nerve as it passes through the rectus abdominus muscle. Anterior wall pain can be distinguished from intra-abdominal pain by documenting that pain increases with maneuvers that tense the abdominal muscles. It has also been proposed that abdominal wall pain may be due to a myofascial trigger point in the rectus abdominus muscle.

Tender Points
Definition
Tender points are focal areas of hyperalgesia that tend to occur at muscle tendon junctions. Tender points are differentiated from trigger points due to the absence of a taut band of muscle tissue or local hyperirritability (“jump response”) when palpated.

Despite the lack of local hyperirritability or a palpable band of tissue, some practitioners have treated tender points with injections of local anesthetic, corticosteroids, or botulinum toxin, similar to the treatment of trigger points.

Associated Disorders
Fibromyalgia
Fibromyalgia is a chronic condition characterized by widespread pain with hyperalgesia and allodynia. Constitutional symptoms such as fatigue, impaired cognition, and disrupted sleep can also occur. Early diagnostic criteria for fibromyalgia (1990) included 3 or more months of widespread pain above and below the waist, on both sides of the body, and along the midline, with at least 11 of 18 specific tender points. The defined bilateral areas from the American College of Rheumatology (ACR) criteria are occipital, low cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, and knee medial fat pad. However, 2010 diagnostic criteria from ACR, which were designed to facilitate diagnosis in a general practice setting, did not include a tender point exam but instead relied on the presence of widespread pain and other symptoms.

Literature Review
Assessment of efficacy for therapeutic intervention involves a determination of whether an intervention improves health outcomes. The optimal study design for this purpose is a randomized controlled trial (RCT) that includes clinically relevant measures of health outcomes.

We limited our literature review to RCTs given the likelihood of selection bias for treatments related to pain. We focused on identifying RCTs with sham controls and blinded outcome
measures with independent assessors given the potential for placebo effects with pain treatments.

**Trigger Point injections**  
**Myofascial Pain Syndrome**

The evidence on trigger point injections for myofascial pain syndrome includes RCTs.

**Randomized Controlled Trials**  
**Lidocaine Injection vs Physical Therapy**

A 2016 RCT by Lugo et al evaluated the efficacy of lidocaine injection and physical therapy (PT) to treat myofascial pain syndrome. Strengths of this trial included the randomization procedures, power analysis, and assessor blinding. Patients (N=127) with shoulder girdle myofascial pain syndrome for at least 6 weeks and visual analog scale (VAS) scores for pain greater than 40 mm received PT, a single injection of lidocaine, or both treatments together. The primary outcome (VAS pain rating at 1 month) did not differ significantly across the 3 groups (lidocaine, 44.2; PT, 37.8; combined therapy, 40.8). Most secondary outcome measures (function, depression, quality of life) were also similar across groups.

**Lidocaine Injection vs a Lidocaine or Placebo Patch**

A 2009 RCT with 60 patients compared use of a lidocaine infiltration, lidocaine patch, or placebo patch for the treatment of myofascial pain syndrome. Strengths of this trial included allocation concealment for the lidocaine and placebo patches, blinded evaluation, and sample size calculations for adequate power. Similar reductions in pain and pain thresholds with the 2 lidocaine treatments were reported, but significantly less discomfort was associated with the lidocaine patch than with injection (p<0.001). With the lidocaine patch, pain decreased from 84.0 to 17.25; with lidocaine injection, pain decreased from 79.95 to 14.30 (baseline vs posttreatment p<0.001; scale range, 0-100). With the placebo patch, pain on movement remained unchanged (78.35 at baseline vs 77.50 at day 9).

**Lidocaine Injection vs Dry Needling or Sham Stimulation**

In 2014, Couto et al reported on a sham-controlled, double-blind randomized trial of 78 patients that compared trigger point injections with lidocaine to paraspinal intramuscular stimulation, or sham stimulation. Trial strengths included intention-to-treat analysis, adequate power, and Bonferroni correction for multiple comparisons. Lidocaine 0.2-to-0.5 mL was injected with each needle penetration when a visible local twitch response was evoked. Paraspinal dry needling was applied in the spinal segment of the nerve roots associated with the dermatome, myotome, or sclerotome where the trigger points were found. The placebo control used an electroacupuncture device with no current passing through the electrodes. At baseline, VAS scores were similar across the 3 groups, with mean scores ranging from 6.59 to 6.66 out of 10. All 3 groups improved over time for the primary outcomes of pain and pain threshold. Outcomes were significantly improved for both intervention groups than for sham, although the difference in VAS scores between the lidocaine injection group and sham stimulation was only 1.01 on a 10-point scale.

Local anesthetic (n=35) injected into a trigger point was compared to dry needling (n=23) in the upper trapezius muscle in a 1994 study by Hong et al. For the lidocaine injection, a needle was inserted into the trigger point with in-and-out movement within the subcutaneous tissue (20-60 insertions), with a drop of anesthetic released each time the needle was inserted into the taut band. This procedure was followed by stretching exercises at home. Dry needling was performed in the same manner but without lidocaine. Twenty-six (74%) patients treated with local anesthetic and 15 (65%) with dry needling exhibited a local twitch response and were included in the analysis. Pain intensity at baseline, measured by a 0-to-10 numeric rating scale (NRS) for pain, was similar for both groups (lidocaine, 7.88; dry needling, 7.80). All patients who had a local twitch response reported minimal-to-no pain immediately postprocedure. Two weeks posttreatment, pain intensity remained significantly lower in the lidocaine group (0.96).
than in the dry needling group (4.98). Blinded evaluation found no significant differences between groups for pain threshold or range of motion.

**Corticosteroid Injection vs Dry Needling**

In 2017, Brennan et al reported on a partially blinded, noninferiority RCT comparing corticosteroid injections (n=25 hips) to dry needling (n=25 hips) for patients with greater trochanteric pain syndrome (previously called greater trochanteric bursitis), a chronic, intermittent pain syndrome involving tenderness over the lateral hip. The trial was powered with a planned enrollment of 50 patients, using a 2-sample \(t\) test for noninferiority and a noninferiority margin of 1.5. Patients were randomized to a corticosteroid injection or to a dry injection by an orthopedic surgeon or a physician assistant and followed at the provider’s discretion over 6 weeks. At 6 weeks, NRS scores for pain did not differ significantly between groups (difference, -1.12; 95% confidence interval [CI], -2.99 to 0.74). Similarly, there were no significant differences in functional outcomes or medication use.

**Section Summary: Myofascial Pain Syndrome**

The evidence on the treatment of myofascial pain syndrome with lidocaine injections includes randomized comparisons to PT, lidocaine patches, sham stimulation, and dry needling. Lidocaine injections into trigger points were effective at improving subjective pain ratings to the same degree as PT or lidocaine patches, and slightly more effective than sham stimulation. Lidocaine injection was less effective for improving pain ratings than paraspinal dry needling in 1 trial and more effective than dry needling in another. In the latter trial, there was no significant benefit of lidocaine injection on objective outcome measures. The small number of trials, different comparators, and lack of consistent improvements in outcomes limit the ability to make conclusions. Further high-quality RCTs are needed to determine whether trigger point injections improve outcomes for patients with myofascial pain syndrome.

**Complex Regional Pain Syndrome**

No RCTs on injections for the treatment of complex regional pain syndrome (CRPS) were identified. One case report from 2000 described the treatment of CRPS with progressive trigger point manipulations, beginning with desensitization and gentle massage followed by steroid injections. Trigger point injection for CRPS is also described as a treatment modality in a 2000 review. A 2013 Cochrane review on interventions for CRPS included a variety of allopathic and alternative treatment approaches, but did not include trigger point injections.

**Section Summary: Complex Regional Pain Syndrome**

Evidence on treatment of CRPS with trigger point injections is very limited, with no recent literature identified for this treatment approach.

**Abdominal Wall Pain**

In 2016, Oor et al reported on a systematic review of therapies for abdominal cutaneous nerve entrapment syndrome. Seven studies met reviewers’ inclusion criteria, 4 (n=179 patients) of which evaluated treatment with trigger point injections and 4 of which evaluated treatment with anterior neurectomy (1 study included patients in both groups). All studies that evaluated trigger points injections were case series or retrospective cohorts, in which 70% to 100% of patients reported improvements in pain in the short term.

**Lidocaine Injection vs Ischemic Compression Therapy**

In 2015, Montenegro et al published an RCT with 30 women who had chronic pelvic pain with abdominal wall trigger points. Patients were assigned to lidocaine injection into a trigger point or ischemic compression using PT; both treatments were administered once a week for 4 weeks. The primary outcome, assessed in blinded fashion, was the clinical response rate, defined as a reduction of at least 50% in VAS score or a significant subjective impact on activities of daily living. Secondary outcomes were the proportion of patients who experienced pain relief, pain threshold, and pain tolerance on the trigger point. Clinical response rates and pain relief were significantly better in the injection group at 1, 4, and 12 weeks posttreatment. At 1 and 4 weeks...
After treatment, the clinical response rate was 80% for lidocaine injection and 40% for ischemic compression ($p=0.018$). At 12 weeks, clinical response rates were 73.3% for lidocaine injection and 13.3% for ischemic compression ($p<0.001$). Power analysis had indicated that 60 subjects would be needed, but, after interim analysis, the trial was discontinued due to the lower efficacy of ischemic compression.

**Section Summary: Abdominal Wall Pain**

A single RCT was identified that evaluated lidocaine injection in women who had chronic pelvic pain with abdominal wall trigger points. Additional study in a larger population is needed to permit greater certainty on the efficacy of this treatment approach.

**Tender Point Injections**

**Fibromyalgia**

In 2014, Staud et al reported a double-blinded RCT with 62 patients with fibromyalgia who received injections of lidocaine (100 or 200 mg) or saline. Each patient received 4 injections, containing 5 mL of saline or lidocaine into the trapezius (shoulder) and gluteal (low back) muscles. Ratings of mechanical and heat pulses to the shoulders, arms, back, and legs were reduced with lidocaine. However, overall clinical fibromyalgia pain decreased by a similar amount (overall VAS score decreased ≈ 38%) in all 3 groups, suggesting a large placebo effect of the injection with no additional benefit of the anesthetic. Patients' estimates of receiving lidocaine or placebo were similar across groups, demonstrating successful allocation concealment in this double-blinded trial.

**Section Summary: Fibromyalgia**

A single RCT was identified that evaluated the efficacy of lidocaine injections in patients with fibromyalgia. It found a strong placebo effect, with lidocaine injection being not more effective than saline at reducing fibromyalgia pain.

**Summary of Evidence**

For individuals who have myofascial pain syndrome who receive trigger point injections, the evidence includes several randomized controlled trials (RCTs) and a systematic review of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Lidocaine injections have been compared to physical therapy, lidocaine patches, sham stimulation, and dry needling. Some trials have reported that injecting lidocaine into trigger points improve subjective pain ratings to the same degree as physical therapy or lidocaine patches, but only slightly more than sham stimulation. Other trials have found that lidocaine injection was superior to dry needling on subjective pain ratings, but there was no significant benefit with lidocaine injection assessed on objective outcome measures. These results suggest a strong placebo effect of the treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have complex regional pain syndrome who receive trigger point injections, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Evidence on treatment of complex regional pain syndrome with trigger point injections is very limited, with only case series published and no recent literature identified for this treatment approach. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have abdominal wall pain who receive trigger point injections, the evidence includes 1 RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The single RCT evaluated lidocaine injections in women who had chronic pelvic pain and abdominal wall trigger points. Additional study in a larger population is needed to permit greater certainty about the efficacy of this treatment approach. The evidence is insufficient to determine the effects of the technology on health outcomes.
For individuals who have fibromyalgia who receive tender point injections, the evidence includes 1 RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The single RCT identified evaluated the efficacy of lidocaine injections in patients with fibromyalgia. It found a strong placebo effect, with lidocaine injection being not more effective than saline at reducing fibromyalgia pain. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Clinical Input from Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests from Blue Cross Blue Shield Association, input was received from 6 specialty societies (10 reviewers) and 3 academic medical centers in 2016. Input focused on trigger point injections for myofascial pain syndrome. There was general consensus that trigger point injections are considered medically necessary for select patients with myofascial pain syndrome who have failed conservative therapy, when administered as part of a comprehensive therapy program. Input agreed that ultrasound guidance was investigational.

Practice Guidelines and Position Statements
The American Society of Anesthesiologists (ASA) and the American Society of Regional Anesthesia and Pain Medicine (ASRA) published joint practice guidelines on chronic pain management in 2010. ASA and ASRA found insufficient evidence to evaluate the efficacy of trigger point injections to provide pain relief compared to sham injections (category D evidence). Based on observational findings, ASA and ASRA concluded that “trigger point injections may be considered for treatment of patients with myofascial pain as part of a multimodal approach to pain management.”

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers. The following local Medicare carriers have positive coverage decisions for trigger point injections:
- First Coast Service Options
- Cahaba Government Benefit Administrators
- Noridian Healthcare Solutions
- Novitas Solutions Inc.
- Wisconsin Physician Service Insurance Corp

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
<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
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<th>Completion Date</th>
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<td>Ongoing</td>
<td>Facet Versus Trigger Point Injection for Management of Chronic Muscular Neck Pain: A Randomized Clinical Trial and Creation of a Clinical Prediction Algorithm</td>
<td>43</td>
<td>Dec 2016 (ongoing)</td>
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<tr>
<td>Unpublished</td>
<td>Using Saline for Myofascial Pain Syndromes (USAMPS)</td>
<td>51</td>
<td>Nov 2016 (terminated)</td>
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References


### Documentation for Clinical Review

Please provide the following documentation (if when requested):
- History and physical and/or consultation notes including:
  - Conservative treatment(s), duration, and patient response
  - Diagnostic evaluation
  - Functional limitation(s)
- Prior procedure(s) and response (if applicable)
- Radiology report(s)
- Electrodiagnostic studies (if applicable)

### Post Service

- Procedure report(s)

### Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

**MN/IE**
The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<tr>
<td><strong>CPT®</strong></td>
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<td>Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)</td>
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</tr>
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<td>77021</td>
<td>Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation</td>
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**HCPCS**
None

**ICD-10 Procedure**
None
### Policy History

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

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<th>Effective Date</th>
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<tr>
<td>11/01/2016</td>
<td>BCBSA medical policy adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>06/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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### Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**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. Please call (800) 541-6652 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.