

## Dry Needling

**Policy MP-059**

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**Reviewed/Revised Date:** 07/17/2024

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**Current Effective Date:** 07/17/2024

### Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, CHIP and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. **This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.**

### Description:

Globally, the prevalence of neck pain increased by 21% from 2005 to 2015, affecting more than 358 million people in 2015. In the 2015 National Health Interview Survey, almost 39 million adults reported having neck pain, an age-adjusted rate of 15.7% of the U.S. population. Myofascial pain—a pain in the muscle or connective tissue (fascia) that is usually associated with myofascial trigger points (TrPs)—is present in approximately 30% to 85% of patients who present with pain at a primary care facility or pain clinic.

Migraines or severe headaches, face or jaw pain, or low back pain (LBP), respectively, affect more than 36 million, 10 million, and 72 million adults in the United States. The age-adjusted prevalence among adults in the United States is 15% for migraine or severe headaches, 29% for LBP, 4% for face or jaw pain, 10% to 15% for temporomandibular disorders (TMD), and 18% to 26% for shoulder pain. Knee pain affects approximately 25% of adults.

Dry needling involves the provider inserting a dry solid filament needle through the skin and into one or two muscles in (CPT 20560) and into three or more muscles in (CPT 20561). Indicated for myofascial pain relief and movement impairments, trigger points (focal, discrete spots of hypersensitive irritability identified within bands of muscle) are often the target of insertion. These points cause local or referred pain and may be formed by acute or repetitive trauma to the muscle tissue. This procedure, also known as dry needling or trigger-point acupuncture, does not involve the administration of injectable therapeutic agents.

## Policy Statement and Criteria

### 1. Commercial Plans/CHIP

U of U Health Plans does NOT cover dry needling for any indication as it is considered investigational, since current published literature is insufficient to determine proven benefit.

### 2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: <https://medicaid.utah.gov/utah-medicaid-official-publications/> or the [Utah Medicaid code Look-Up tool](#)

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

## Clinical Rationale

The overall body of evidence evaluated indicates that dry needling (DN) is safe and well tolerated in adults with mechanical neck and/or trapezius muscle pain. Compared with inactive controls, DN showed significant and consistent improvement in pain, disability, and function as well as clinically meaningful improvements in patient-reported pain. Results of studies comparing DN with active treatments showed similar outcomes between the groups for pain, function, and disability in most studies; however, DN was less efficacious in some studies. There was also considerable variation in active treatments across the studies.

DN versus control (i.e., sham DN, inactive DN, or no DN) treatment was associated with statistically significant improvements in self-reported pain, PPT, ROM, neck disability, QOL, and analgesic use. One study found that DN versus sham DN did not improve self-rated recovery. One measure of pain across 4 studies showed that the magnitude of effect of the benefit of DN was clinically meaningful.

Patient-reported pain outcomes were not significantly improved in the majority of studies identified or showed less improvement with DN when compared with other active treatments. Comparisons of efficacy may have been hampered by the heterogeneity in active treatments across the studies as well as questions about the relevance of the comparator treatments.

DN versus other active treatment was also associated with no significant improvement in other outcomes such as neck disability, PPT, ROM, QOL, and analgesic use. A few studies have reported mild reactions such as self-resolving muscle soreness and sweating but no studies reported major adverse events.

While DN produced better outcomes than sham DN or inactive control, and had similar efficacy as most other alternative treatments, there is a lack of long-term follow-up data to determine the durability of any benefits. Patients were followed in most of the reviewed studies for a short time ranging from immediately after treatment to 6 months, with only 1 study having 1-year follow-up.

DN treatment protocols, concomitant use (or not) of stretching or physical therapy, methods for confirming pain originating from trigger points, clinical history, and patient inclusion criteria varied

somewhat among the studies, making it difficult to compare study results and draw definitive conclusions about relative efficacy.

It is unclear whether the benefits achieved by DN in terms of pain relief and improved function are of sufficient magnitude to outweigh the potential discomfort of a needle insertion and manipulation, particularly compared with other noninvasive treatments.

As it relates to other indications for use of dry needling, the overall body of evidence evaluated indicates DN is safe and well tolerated in adults with headache/migraine, jaw muscle pain, LBP, shoulder pain, or knee pain. Within each indication, the studies varied in terms of patient inclusion criteria, DN treatment protocols, active comparators, and concomitant use (or not) of other therapies (e.g., PT, medications), making it difficult to compare study results and draw definitive conclusions about relative efficacy. Furthermore, the underlying cause and type of pain often varied within an indication (acute versus chronic, surgical versus traumatic). Importantly, standardized methods for confirming pain originating from trigger points remain to be defined. Therefore, while results suggest that DN might be beneficial for some patient populations, there is insufficient evidence to provide definitive conclusions regarding the efficacy of DN.

Multiple research studies support short-term and/or immediate effect on pain and functional outcomes; multiple systematic reviews, as recent as 2024, have concluded that dry needling is more effective in the short term for decreasing pain when compared to sham or placebo treatment. However, there is still currently weak evidence for dry needling effect on functional outcomes or quality of life. The evidence to support dry needling in the long term for decreasing pain or improving functional outcomes is currently lacking because no previous reviews have included evidence of long-term effects. This is consistent with the most recent literature as the majority states long-term effects need to be assessed and are currently lacking.

## **Applicable Coding**

### **CPT Codes**

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

### **HCPCS Codes**

No applicable HCPCS codes

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