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Coalition of State Rheumatology Organizations

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Robert Kettler, MD
Contractor Medical Director
WPS Government Health Administrators
1717 W Broadway
Madison, WI 53713

Submitted electronically: Robert.kettler@wpsic.com, LCDCAC@wpsic.com, and Policycomments@wpsic.com

RE: Multijurisdictional Contractor Advisory Committee Meeting: Trigger Point Injections

Dear Dr. Kettler,

The Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist.

Below we provide feedback on the use of trigger point injections (TPI) in rheumatic conditions pursuant to the multi-jurisdictional contractor advisory committee (CAC) meeting on this topic.

TPI in Rheumatology

Rheumatologists diagnose, treat and manage a wide array of musculoskeletal pain and related conditions, including myofascial pain syndrome (MPS). MPS is caused by myofascial trigger points (MTrPs), essentially "knots" of muscle that do not relax. Many rheumatology practices have found that TPI injections, which contain an anesthetic to numb the pain and a corticosteroid medication to reduce inflammation, are an effective tool to help loosen and relax muscles, and alleviate pain.

Rheumatologists acknowledge there is limited empirical data to support the use of TPI and that study of this intervention is still underway. Nevertheless, anecdotally, the clinical phenomenon is real[1] and has been "helpful in decreasing pain and improving range of motion in conjunction with a comprehensive exercise and rehabilitation program" in some patients.[2]

Key Questions

CMS poses a number of questions for its subject matter experts (SMEs) selected to participate in the upcoming CAC meeting. CSRO offers feedback on selected questions based on feedback from rheumatologists that have employed TPI in clinical practice.

[1] https://academic.oup.com/rheumatology/article/54/3/392/1796114
[2] https://pubmed.ncbi.nlm.nih.gov/8860801/

1. **Do you agree with the following definitions (and if not, how would you define)?**

   We generally agree with the definitions presented, but urge you to adopt a revised definition for trigger point (see redline edits below):

   - Trigger point – ~~a hyperirritable spot~~ Myofascial pain in skeletal muscle usually accompanied by other hypertonic muscle groups that is associated with two of the following: ~~a hypersensitive palpable nodule in~~ a taut band~~, and frequently associated with referred pain~~ a hyperirritable spot, and referred pain.

2. Do you agree clinical history and physical exam requires: a taut band, a hypersensitive spot and/or nodule, and referred pain to diagnose trigger points?

Trigger points are a hallmark of myofascial pain and are diagnosed based upon finding at least two of the following: a taut band, hyperirritable spot, and referred pain [1-3]. Trigger points are usually (but not always) accompanied by other hypertonic muscle groups.

3. What injectant should be used during trigger point injections? Is there any evidence to guide the type of injectant used and if a combination (such as local anesthetic alone or in combination with steroids) is more effective?

Trigger point injection is a low-risk intervention that some find helpful in the management of patients with isolated muscle spasm and taut bands [4-5], recognizing there is little consensus and no study confirming whether injecting local anesthetic, or combination of local anesthetic, is more effective. Some rheumatologists note that, in their experience, combination therapy is better with longer lasting results and better pain relief.

4. What is the expected duration of relief from trigger point injections? Does it vary with the agent used or the underlying disease process?

A successful trigger point injection will have a duration of action of 1 to 4 months [6].

5. What assessment should be done before and after trigger point injections?

For rheumatology indications, physicians tell us that a history and physical examination is required, along with imaging and lab testing, if medically necessary.

6. What percent improvement is considered a positive response? What criteria should be met to consider repeating injections? What evidence or societal guidance supports this?

Rheumatologists providing feedback said there is no standard definition of a positive or negative response. Some rheumatologists consider a positive response to an injection at least 25% improvement in pain severity, with a duration of at least 4 weeks.

7. Is there evidence for or guidance on repeating the injection to the same area? If yes, how frequently should trigger point injections be performed?

Rheumatologists providing feedback noted there is no evidence or guidance on how frequently a single area should be injected, but some noted they would not inject a single area more frequently than every 3 months.

8. Is there a limit to how many trigger point injections can be performed during the same session? What evidence or societal guidance supports this?

Rheumatologists providing feedback were not aware of any evidence or societal guidance discussing such limits. However, as steroids may be used in some trigger point injections, there may be limitations on the amount steroids given in one session and the cumulative amount over time.

9. For what duration should trigger point injections be utilized? What evidence or societal guidance supports this?

Rheumatologists providing feedback were not aware of any evidence or societal guidance addressing duration of therapy.

10. Do you agree trigger point injections should be performed as sole procedure and not in conjunction with other procedures during same session? Please explain why?

Some rheumatologists told us that trigger point injections are commonly given with joint injections and nerve blocks at the same session.

11. Are there circumstances where image guidance is necessary for trigger point injections?

Rheumatologists providing feedback were not aware of any evidence or societal guidance addressing image guidance for trigger point injections.

12. What absolute contraindications are there for trigger point injections?

Rheumatologists providing feedback reported that a drug allergy to the medication being injected is an absolute contraindication.

13. Rate the strength of evidence to support the effectiveness of Trigger Point Injections to relieve pain for the following conditions using very insufficient, low, moderate, or high quality to describe supporting evidence:

Rheumatologists provided the following feedback on the below conditions:

- **Myofascial pain disorders** – Studies with observational findings suggest that trigger point injections may provide relief for patients with myofascial pain for assessment periods ranging from 1 to 4 months (*Category B2 evidence*). Consultants and members of the American Society of Anesthesiology (ASA) and American Society of Regional Anesthesia and Pain Medicine (ASRA) agree that trigger point injections should be used for patients with myofascial pain [6].
- **Chronic low back pain** - Trigger point injections may be beneficial in patients with tender points (in the back or elsewhere) associated with the myofascial pain syndrome [7].
- **Non-radicular neck pain** - Trigger point injections a low-risk intervention that some find helpful in the management of patients with isolated muscle spasm and taut bands [4,5].
- **Fibromyalgia** - There have been few studies of trigger point or tender point injections, electromyography (EMG) biofeedback, chiropractic, or massage in the treatment of

fibromyalgia. Most of these reports are from small case series or lack quality control. Anecdotally, trigger point injections can relieve acute tender point and trigger point pain exacerbations and are not uncommonly utilized.

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Thank you for considering our comments. We look forward to continuing the dialogue on this and other topics where Medicare Administrative Contractors (MACs) are considering the development of local coverage policies and associated articles. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

Madelaine A. Feldman, MD, FACR
Vice President, Advocacy and Government Affairs
Coalition of State Rheumatology Organizations

Footnotes

1. Simons DG, Travell JG, Simons PT. Upper half of body. In: Travell and Simons' Myofascial Pain and Dysfunction: The Trigger Point Manual, 2nd ed, Williams & Wilkins, Baltimore 1999
2. Lavelle ED, Lavelle W, Smith HS. Myofascial trigger points. Anesthesiol Clin. 2007 Dec;25(4):841-51, vii-iii.
3. Fernández-de-Las-Peñas C, Dommerholt. International Consensus on Diagnostic Criteria and Clinical Considerations of Myofascial Trigger Points: A Delphi Study. Pain Med. 2018;19(1):142
4. Esenyel M, Caglar N, Aldemir T. Treatment of myofascial pain. Am J Phys Med Rehabil. 2000;79(1):48.
5. Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. Am Fam Physician. 2002;65(4):653.
6. American Society of Anesthesiologists (ASA) and American Society of Regional Anesthesia and Pain Medicine (ASRA): Practice guidelines for chronic pain management (2010)
7. Roger Chou MD:: Subacute and chronic low back pain: Nonsurgical interventional treatment. Up to Date June 2021