

08.01.31 Dry Needling

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Summary

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.

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 randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. A systematic review of techniques to treat 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. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have myofascial trigger points associated with plantar heel pain who receive dry needling of trigger points, the evidence includes a systematic review of randomized trials. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The systematic review 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 evidence as low to moderate. The evidence for dry needling in patients with plantar heel pain is limited by small patient populations and lack of blinding; therefore, additional, good methodological quality RCTs are needed to strengthen the evidence base. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have myofascial trigger points associated with temporomandibular myofascial pain who receive dry needling of trigger points, the evidence includes 2 RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. One double-blind, sham-controlled randomized trial was identified; it found that 1 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. The second RCT (N = 50) compared dry needling to manual therapy. Both groups experienced improvements from baseline to the end of the study but there was no difference between groups in pain intensity, maximal mouth opening, or disability (using the Neck Disability Index). Methodological quality was limited by a lack of blinding and no reporting of power/sample size calculation. Additional RCTs, especially those with a sham-control group, are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals as a who utilize dry needling as a treatment and/or therapy for miscellaneous conditions (i.e., headache, knee osteoarthritis, pelvic pain, tendinopathy, and whiplash) the evidence includes systematic reviews and randomized controlled trails (RCTs). Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Dry needling is minimally invasive procedure that appears to be safe (carrying a low risk) and represents a promising area of future research as a treatment option for pain management. Overall the studies on dry needling had inconsistent effects on outcomes, with variable improvements in pain pressure threshold, but no improvements in pain scores or function. Additional RCTs, especially those with a sham-control group, are needed to clarify the effects of dry needling comparing multiple protocols. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Additional Information

None

OBJECTIVE

The objective of this evidence review is to evaluate whether dry needling improves the individual's net health outcome.

PRIOR APPROVAL

Not applicable.

POLICY

Dry needling is considered **investigational** for all indications because the evidence is insufficient to determine the technology results in an improvement in the net health outcomes.

POLICY GUIDELINES

Coding

See the [Codes table](#) for details.

BACKGROUND

Myofascial Trigger Points

Myofascial pain is defined by the presence of trigger points which 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 likely a result of injury to muscle fibers, but the pathophysiology is not fully defined. Trigger points can be visualized by magnetic resonance imaging and elastography. The reliability of manual identification of trigger points has not been established.

Dry Needling

Dry needling targets a trigger point but differs from a trigger point injection because there is no injection of medication or fluid (e.g., anesthetics or corticosteroids). 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 (eg, 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.

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. 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.

Regulatory Status

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

RATIONALE

This evidence review was created in November 2018 and has been updated regularly with searches of the PubMed database. The most recent literature update was performed through July 2025.

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.

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.

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 (Table 1).

In 2023 Hayes, a symplr company, completed a Health Technology Assessment of Dry Needling for Mechanical Neck and/or Trapezius Muscle Pain in Adults which was last reviewed June 30, 2025. The assessment indicated that dry needling (DN), typically coupled with exercise or stretching, for the treatment of adults with mechanical neck and/or trapezius muscle pain associated with trigger points (TrPs) is rated a C. A C rating according to Hayes indicates, “potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns.

Charles et al. (2019) conducted a systematic review of different techniques for treatment of myofascial pain. 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. 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. 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. 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; I²=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.

Table 1. Comparison of Studies Included in SRs

Study ^a	Charles et al (2019) ³	Navarro-Santana et al (2020) ⁴	Navarro-Santana et al (2020) ⁵	Para-Garcia et al (2022) ⁶
Arias-Buría et al (2015)	●			
Arias-Buría et al (2017)			●	●
Arias-Buría et al (2020)		●		
Aridici et al (2016)		●		
Ay et al (2010)	●			
Calvo-Lobo et al (2018)			●	
Campa-Moran et al (2015)	●	●		
Chu et al (1997)	●			

Study^a	Charles et al (2019)³	Navarro-Santana et al (2020)⁴	Navarro-Santana et al (2020)⁵	Para-Garcia et al (2022)⁶
De Meulemeester et al (2017)		●		
DiLorenzo et al (2004)	●			
Dogan et al (2019)		●		
Ekici et al (2021)				●
Fernández-Carnero et al (2017)		●		
Ga et al (2007)	●			
García-de-Miguel et al (2020)		●		
Hayta et al (2016)		●		
Ilibuldu et al (2004)	●	●		
Imani et al (2021)				●
Irnich et al (2002)	●			
Itoh et al (2007)	●	●		
Itoh et al (2014)		●		
Jalilipanah et al (2021)				●
Kamali et al (2018)		●		
Kamanli et al (2005)	●			
Llamas-Ramos et al (2014)	●	●		
Luan et al (2019)		●		
Martín-Rodríguez et al (2019)		●		
Manafnezhad et al (2019)		●		
Mejuto-Vázquez et al (2014)	●	●		
Myburgh et al (2012)		●		
Onat et al (2019)		●		
Pecos-Martín et al (2015)	●	●		
Perez-Palomarez et al (2017)			●	●

Study ^a	Charles et al (2019) ³	Navarro-Santana et al (2020) ⁴	Navarro-Santana et al (2020) ⁵	Para-Garcia et al (2022) ⁶
Rayegani et al (2014)		●		
Salom-Moreno et al (2017)			●	
Segura-Ortí et al (2016)		●		
Sobhani et al (2017)		●		
Sukareechai et al (2019)		●		
Tabatabaiee et al (2019)		●		
Tekin et al (2012)		●		
Tsai et al (2010)	●			
Valiente-Castrillo et al (2020)		●		
Ziaeifer et al (2014)	●	●		
Ziaeifer et al (2016)		●		
Ziaeifer et al (2019)		●		

RCT: randomized controlled trials; SR: systematic reviews.

^a Only RCTs assessing neck and shoulder pain in each SR were included in the table.

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.

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

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 2 to 4). 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 individuals in the trials limits applicability.

Table2: Trials Included in Systematic Review

Study	Llurda-Almuzara et al. (2021)
Bagcier et al. (2020)	●
Cotchett et al. (2014)	●
Eftekharsadat et al. (2016)	●
Rahbar et al. (2018)	●
Rastegar et al. (2017)	●
Uygur et al. (2019)	●

Table 3: Systematic Review Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Llurda-Almuzara et al. (2021)	Inception-2020	6	Patients with heel pain receiving dry needling or comparator (placebo, no intervention, or active comparator)	395 (10 to 49)	RCT	1 to 6 sessions (mean, 4 sessions)

RCT: randomized controlled trial.

Table 4: 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)				
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^2	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 individuals 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, 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.

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

Garcia-de-la-Banda-Garcia et al (2023) conducted an RCT that compared dry needling to manual therapy in 50 individuals with temporomandibular disorders. Participants and physical therapists were unblinded. and each patient received 3 sessions, each 4 days apart. Patients were followed until 2 weeks after the last treatment. Both groups experienced improvements from baseline to the end of the study but there was no difference between groups in pain intensity, maximal mouth opening, or disability (using the Neck Disability Index). The study may have lacked a sufficient number of participants to detect differences between groups; a power/sample size calculation was not reported.

A double-blind, sham-controlled trial of dry needling for the treatment of temporomandibular myofascial pain was reported by Diracoglu et al (2012). Individuals (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

Two RCT evaluating dry needling for the treatment of temporomandibular myofascial pain were identified. One 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 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. The second RCT was active-controlled, but quality is limited by lack of blinding and a small sample size.

Miscellaneous Other Conditions

Clinical Context and Therapy Purpose

The purpose of dry needling in individuals who have pain related to other conditions (i.e. headache, knee osteoarthritis, pelvic pain, tendinopathy, and whiplash) 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 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.

According to the American Society of Regional Anesthesia and Pain Medicine, Myofascial pain is a common, non-articular musculoskeletal disorder characterized by symptomatic myofascial trigger points - hard, palpable, localized nodules within taut bands of skeletal muscle that are painful upon compression. MPS is a chronic condition affecting the connective tissue (i.e., fascia) surrounding the muscles; sensitive points in your muscles (trigger points) cause referred pain in seemingly unrelated parts of the body. MPS typically occurs after a muscle has been contracted repetitively. The large upper back muscles are prone to developing myofascial pain, as well as the heel.

Interventions

The therapy being considered is dry needling.

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.

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

Headaches

Systematic Reviews

Kandeel, et al (2024) completed a systematic review and meta-analysis of 13 RCTs to evaluate the impact of dry needling on disability and pain in individuals with different types of headaches. Headache types varied and included tension-type headaches, migraines, and cervicogenic headaches. Comparator groups consisted of sham interventions, physiotherapy, or pharmacological treatments. The analyses found significant reductions in disability and headache intensity outcomes after one and three-months. However, concerns about the risk of bias in these studies, including inadequate randomization processes and missing outcome data, reduces the confidence in these findings.

Vázquez-Justes et al. (2022) completed a systematic review of randomized clinical trials on headache and dry needling. Of a total of 136 studies, we selected 8 randomized clinical trials published between 1994 and 2019, including a total of 577 patients. Two studies evaluated patients with cervicogenic headache, 2 evaluated patients with tension-type headache, one study assessed patients with migraine, and the remaining 3 evaluated patients with mixed-type headache (tension-type headache/migraine). Quality ratings ranged from low (3/10) to high (7/10). The effectiveness of dry needling was similar to that of the other interventions. Dry needling was associated with significant improvements in functional and sensory outcomes. The authors concluded dry needling should be considered for the treatment of headache and may be applied either alone or in combination with pharmacological treatments. The clinical relevance of their results continues to be limited, since improvements in such parameters as the headache index may not translate into an improvement in quality of life. Thus, caution should be taken when evaluating the potential benefits of this therapy. The authors did admit mild adverse reactions to puncture techniques are frequent, patients rarely present such severe adverse reactions as cardiac tamponade, pneumothorax, or epidural spinal hematoma. None of the articles included reported severe adverse reactions. However, given the low morbidity and mortality associated with DN as compared to the disability potentially caused by headache, and considering that the studies published to date show that DN is effective, low-risk, and affordable, we believe that this technique may be useful for headache management. The authors also reported one of the main limitations of the study is the inability to perform a meta-analysis due to the heterogeneity of methodologies and the highly variable results; this

underscores the need to develop specific protocols to increase the reproducibility and comparability of studies into DN. The definition of the headache index is ambiguous; furthermore, the index is not listed among the outcome measures recommended in the International Headache Society's guidelines for clinical trials. Only the visual analogue scale, diary records of pain intensity, and the need for rescue medication are mentioned in the guidelines. The authors recommended future clinical trials should also specify the criteria for classifying patients and avoid including patients with headache presenting mixed characteristics. Since our literature search was limited to studies published either in Spanish or in English, it may have omitted relevant studies in other languages. Finally, despite the inability to conduct a meta-analysis, it should be noted that all the studies included in our review reported positive results; future reviews should therefore analyze the possibility of a publication bias.

Pourahmadi et al. (2021) completed a systematic review/meta-analysis reporting of 2715 identified studies, 11 randomized clinical trials were eligible for qualitative synthesis and 9 for meta-analysis. Only 4 trials were of high quality. Very low-quality evidence suggested that dry needling is not statistically better than other interventions for improving headache pain intensity in the short term in patients with TTH (SMD -1.27, 95% CI = -3.56 to 1.03, n = 230), CGH (SMD -0.41, 95% CI = -4.69 to 3.87, n = 104), or mixed headache (TTH and migraine; SMD 0.03; 95% CI = -0.42 to 0.48, n = 90). Dry needling provided significantly greater improvement in related disability in the short term in patients with TTH (SMD -2.28, 95% CI = -2.66 to -1.91, n = 160) and CGH (SMD -0.72, 95% CI = -1.09 to -0.34, n = 144). The synthesis of results showed that dry needling could significantly improve headache frequency, health-related quality of life, trigger point tenderness, and cervical range of motion in TTH and CGH. Dry needling produces similar effects to other interventions for short-term headache pain relief, whereas dry needling seems to be better than other therapies for improvement in related disability in the short term. The systematic review suggested that for every one or two patients with TTH treated by dry needling, one patient will likely show decreased headache intensity (number needed to treat [NNT] = 2; large effect) and improved related disability (NNT = 1; very large effect). In CGH, for every three or four patients treated by dry needling, one patient will likely exhibit decreased headache intensity (NNT = 4; small effect) and improved related disability (NNT = 3; medium effect). Further high-methodological quality studies are warranted to provide a more robust conclusion.

Randomized Controlled Trials

Gildir et al. (2019) completed a randomized, double-blind, parallel-group trial, aiming to explore the effectiveness of trigger point dry needling in patients with chronic tension-type headache in reducing headache frequency, intensity and duration, and improvement of health-related quality of life. The 168 patients in 2 neurology clinics with chronic tension-type headache. The participants were randomly assigned to one of two treatment groups for dry needling or sham dry needling, delivered in 3 sessions a week for 2 weeks. The 160 patients fulfilled the study requirements. The dry needling was applied in active trigger points located in the musculature of the head and the neck. The patients received dry needling using sterile stainless-steel acupuncture needles of 0.25×40mm and 0.25×25mm dimensions. The sham dry needling procedure was applied into the adipose tissue located at any area where an active trigger point was absent. The primary outcome measurement was the headache intensity. Secondary outcomes were frequency and duration of headache, and quality of life, assessed by the Short Form-36. All outcomes were measured at baseline, at the end of 2-week, and 1-month follow-up period. The reported results were in the dry needling group, intensity, frequency and duration of headache, and the scores of Short Form-36 subscales were significantly improved after treatment ($P < .05$). In the dry needling group, all the effect sizes for headache variables were large. The authors concluded the results of this clinical trial suggest that trigger point dry needling in patients with chronic tension-type headache is effective and safe in reducing headache intensity, frequency, and duration, and increasing health-related quality of life.

Knee Osteoarthritis in Adults

In 2023 Hayes, a symplr company, completed a Health Technology Assessment which was last reviewed in June 2023 on dry needling for knee osteoarthritis in adults. Hayes provided a C rating for dry needling (DN), typically coupled with exercise or stretching, for the treatment of adults with knee osteoarthritis (KOA). A C rating according to Hayes indicates, “potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing/ However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns.

Pelvic Pain

Wellmark did not identify any RCTs or systematic reviews that meet our trial design criteria that addresses dry needling specifically for the treatment of pelvic pain for outcomes of interest such as symptoms, morbid events, and functional outcomes.

Tendinopathy

Systematic Reviews

Nuhmani et al. (2022) completed a systematic review of randomized controlled trials on dry needling in the management of tendinopathy. The objective of the study is to evaluate the best available evidence on the effectiveness of DN in the management of tendinopathy. Seven randomized control trials were selected. A total of 357 participants were enrolled in the seven included studies, which were on greater trochanteric pain syndrome, lateral epicondylitis, supraspinatus tendinopathy and Achilles tendinopathy. DN was compared with various interventions, including platelet-rich plasma injection, autologous blood injection and non-steroidal anti-inflammatory medication. All the selected studies reported a significant positive effect of DN on pain intensity and other outcome measures, such as patient-specific functional score, disability index, range of motion and health-related quality of life. There are a few limitations of this study such as incomplete descriptions of the DN application technique, variation in the period of assessment, follow-up and time frame in pain reduction limited our ability to judge the impact of the effectiveness of the procedure. Moreover, it is not possible to state that all of the eligible studies were included in the current review. Because of the heterogeneity of the data, a meta-analysis was not undertaken, and a descriptive narrative approach was used to analyze the data. The authors concluded that DN has shown good results for the short-term and medium-term relief of symptoms of tendinopathy and may be considered as one of the many options available for the management of tendinopathy. Because of the limited number of high-quality studies, heterogeneity of the data and lack of standardization of DN treatment methods, the results should be interpreted with caution. High-quality RCTs that assess long-term outcomes are needed to produce good evidence that can be used to guide the management of these conditions. Physical rehabilitation exercises, especially eccentric training, are considered the most effective first line of treatment for tendinopathy; the effectiveness of combination therapy, including eccentric training and dry needling, should be further explored.

Stoychev et al. (2020) reported the effectiveness of dry needling for treatment of tendinopathy has been evaluated in three systematic reviews, seven randomized controlled trials, and six cohort studies. The following sites were studied: wrist common extensor origin, patellar tendon, rotator cuff, and tendons around the greater trochanter. There is considerable heterogeneity of the needling techniques, and the studies were inconsistent about the therapy used after the procedure. Most systematic reviews and randomized controlled trials support the effectiveness of tendon needling. There was a statistically significant improvement in the patient-reported symptoms in most studies. Some studies reported an objective improvement assessed by ultrasound. Two studies reported complications. Current research provides initial support for the efficacy of dry needling for tendinopathy treatment. It seems that tendon needling is minimally invasive, safe, and inexpensive, carries a low risk, and represents a promising area

of future research. In further high-quality studies, tendon dry needling should be used as an active intervention and compared with appropriate sham interventions. Studies that compare the different protocols of tendon dry needling are also needed.

Whiplash-Associated Disorders

Randomized Controlled Trial

Sterling et al. (2015) completed a randomized controlled trial investigating the effectiveness and cost-effectiveness of dry-needling and exercise compared with sham dry-needling and exercise for chronic whiplash-associated disorders (WAD). The setting was a single university center and 4 physiotherapy practices in Queensland, Australia. Eighty patients with chronic WAD (>3 months) were enrolled between June 2009 and August 2012 with 1-year follow-up completed in August 2013. The interventions were 6 weeks of dry-needling to posterior neck muscles (n = 40) and exercise or sham dry-needling and exercise (n = 40). The primary outcomes of the Neck Disability Index (NDI) and self-rated recovery were measured at baseline, 6 and 12 weeks, 6 and 12 months by a blinded assessor. Analysis was intention to treat. An economic evaluation was planned but missing data deemed further analysis unwarranted. Seventy-nine patients (99%) were followed up at 6 weeks, 78 (98%) at 12 weeks, 74 (93%) at 6 months, and 73 (91%) at 12 months. The dry-needling and exercise intervention was more effective than sham dry-needling and exercise in reducing disability at 6 and 12 months but not at 6 and 12 weeks. The treatment effects were small and not clinically worthwhile. At 6 weeks, the treatment effect on the 0-100 NDI was -0.3 (95% confidence interval -5.4 to 4.7), 12 weeks -0.3 (-5.2 to 4.9), 6 months -4.4 (-9.6 to -0.74), and 12 months -3.8 (-9.1 to -0.5). There was no effect for self-rated recovery. In patients with chronic WAD, dry-needling and exercise has no clinically worthwhile effects over sham dry-needling and exercise.

Section Summary: Miscellaneous Other Conditions

While dry needling may be a promising therapy for the miscellaneous other conditions, heterogeneity in the dry needling treatment protocols, including needling frequency and use of ultrasound guidance, and use of other concomitant therapies limit the generalizability and strength of the findings; therefore, additional RCTs are needed to strengthen the evidence base.

Adverse Events

In a 2014 prospective survey (Brady et al.) -of 39 physical therapists, providing 7629 dry needling treatments, reported 1463 (19.18%) mild adverse events (bruising, bleeding, pain) and no serious adverse events.

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 (AAOMPT)

In 2009, the AAOMPT issued a statement that dry needling fell within the scope of physical therapist practice. In support of this position, the Academy stated, “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.”

American Physical Therapy Association

In 2023, the American Physical Therapy Association published an updated guideline on nonarthritic heel pain (plantar fasciitis). The guideline stated that dry needling of myofascial trigger points in the following areas should be used: gastrocnemius, soles, and plantar muscles of the foot. The evidence supports the efficacy of this technique for pain and long-term function and improved disability, especially in patients with chronic heel pain (defined as lasting more than 1 month). The recommendation was based in part on the systematic review conducted by Llurda-Almuzara discussed above, and more recent studies with methodological limitations including lack of a sham control comparison group.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review can be located at clinicaltrials.gov.

REFERENCES

1. Bernstein CD, Yonter S, Pradeep A, Shah JP, Weiner DK. Fibromyalgia and Myofascial Pain Syndromes. In: Halter JB, Ouslander JG, Studenski S, High KP, Asthana S, Supiano MA, Ritchie CS, Schmader K. eds. Hazzard's Geriatric Medicine and Gerontology, 8e. McGraw Hill; 2022. Available at: <https://accessmedicine-mhmedical-com.proxy.cc.uic.edu/content.aspx?bookid=3201§ionid=266882376>.
2. Alvarez DJ, Rockwell PG. Trigger points: diagnosis and management. *Am Fam Physician*. Feb 15 2002; 65(4): 653-60. PMID 11871683
3. Charles D, Hudgins T, MacNaughton J, et al. A systematic review of manual therapy techniques, dry cupping and dry needling in the reduction of myofascial pain and myofascial trigger points. *J Bodyw Mov Ther*. Jul 2019; 23(3): 539-546. PMID 31563367
4. Navarro-Santana MJ, Sanchez-Infante J, Fernández-de-Las-Peñas C, et al. Effectiveness of Dry Needling for Myofascial Trigger Points Associated with Neck Pain Symptoms: An Updated Systematic Review and Meta-Analysis. *J Clin Med*. Oct 14 2020; 9(10). PMID 33066556
5. 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
6. 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
7. Llurda-Almuzara L, Labata-Lezaun N, Meca-Rivera T, et al. Is Dry Needling Effective for the Management of Plantar Heel Pain or Plantar Fasciitis? An Updated Systematic Review and Meta-Analysis. *Pain Med*. Jul 25 2021; 22(7): 1630-1641. PMID 33760098

8. Bagcier F, Yilmaz N. The Impact of Extracorporeal Shock Wave Therapy and Dry Needling Combination on Pain and Functionality in the Patients Diagnosed with Plantar Fasciitis. *J Foot Ankle Surg.* 2020; 59(4): 689-693. PMID 32340838
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
11. Rahbar M, Kargar A, Eslamian F, Dolatkah N. Comparing the efficacy of dry needling and extracorporeal shock wave therapy in treatment of plantar fasciitis. *J Mazandaran Univ Med Sci.* 2018;28(164):53-62.
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
13. Uygur E, Aktaş B, Eceviz E, et al. Preliminary Report on the Role of Dry Needling Versus Corticosteroid Injection, an Effective Treatment Method for Plantar Fasciitis: A Randomized Controlled Trial. *J Foot Ankle Surg.* Mar 2019; 58(2): 301-305. PMID 30850099
14. García-de la-Banda-García R, Cortés-Pérez I, Ibancos-Losada MDR, et al. Effectiveness of Dry Needling versus Manual Therapy in Myofascial Temporomandibular Disorders: A Single-Blind Randomized Controlled Trial. *J Pers Med.* Sep 21 2023; 13(9). PMID 37763182
15. Diraçoğlu 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.* 2012; 25(4): 285-90. PMID 23220812
16. 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): 134-40. PMID 25125935
17. American Academy of Manual Orthopaedic Physical Therapists. AAOMPT position statement on dry needling. 2009; https://www.aaompt.org/Main/About_Us/Position_Statements/Main/About_Us/Position_Statements.aspx?hkey=03f5a333-f28d-4715-b355-cb25fa9bac2c. Accessed July 2025.
18. Koc TA, Bise CG, Neville C, et al. Heel Pain - Plantar Fasciitis: Revision 2023. *J Orthop Sports Phys Ther.* Dec 2023; 53(12): CPG1-CPG39. PMID 38037331
19. Pourahmadi, Mohammadreza et al. "Dry Needling for the Treatment of Tension-Type, Cervicogenic, or Migraine Headaches: A Systematic Review and Meta-Analysis." *Physical therapy* vol. 101,5 (2021): pzab068. doi:10.1093/ptj/pzab068
20. Gildir, S., Tüzün, E. H., Eroğlu, G., et al. 2019. A randomized trial of trigger point dry needling versus sham needling for chronic tension-type headache. *Medicine*, 98(8), e14520. <https://doi.org/10.1097/MD.00000000000014520>
21. Vázquez-Justes D., Yarzabal-Rodríguez R., Doménech-García V., Science Direct. Effectiveness of dry needling for headache: A systematic review. Volume 37, Issue 9, November–December 2022, Pages 806-815.

22. George, A., VanEtten, L., Briggs M., Dry Needling for Female Chronic Pelvic Pain: A Case Series, *Journal of Women's Health Physical Therapy: January/April 2018 - Volume 42 - Issue 1* - p 8-16 doi: 10.1097/JWH.0000000000000093
23. Nuhmani S., Hussian Khan M., Ahsan M., et al. Dry needling in the management of tendinopathy: A systematic review of randomized control trials. January 2023. *Bodywork and Movement Therapies. Myofascial Pain and Treatment. Volume 33. P 128-135.* Published: September 22, 2022. DOI:<https://doi.org/10.1016/j.jbmt.2022.09.021>
24. Stoychev, Vladimir et al. "Dry Needling as a Treatment Modality for Tendinopathy: a Narrative Review." *Current reviews in musculoskeletal medicine* vol. 13,1 (2020): 133-140. doi:10.1007/s12178-020-09608-0
25. 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.* 2014 Aug;22(3):134-40. doi: 10.1179/2042618613Y.0000000044. PMID: 25125935; PMCID: PMC4101552.
26. France S, Bown J, Nowosilskij M, et al. Evidence for the use of dry needling and physiotherapy in the management of cervicogenic or tension-type headache: a systematic review. *Cephalalgia.* 2014 Oct;34(12):994-1003. doi: 10.1177/0333102414523847. Epub 2014 Mar 12. PMID: 24623124.
27. Tough EA, White AR, Cummings TM, et al. Acupuncture and dry needling in the management of myofascial trigger point pain: a systematic review and meta-analysis of randomized controlled trials. *Eur J Pain* 2009; 13:3.
28. Jayaseelan DJ, T Faller B, H Avery M. The utilization and effects of filiform dry needling in the management of tendinopathy: a systematic review. *Physiother Theory Pract* 2022; 38:1876.
29. Kandeel M., Morsy MA., Al Khodair KM., et al., Dry needling techniques as a treatment for improving disability and pain in patients with different types of headache: A systematic review and meta-analysis. *Complement Ther Med.* 2024 Nov;86:103085. doi: 10.1016/j.ctim.2024.103085. Epub 2024 Sep 15. PMID: 39288839.
30. UpToDate. Isaac Z., Atlas SJ., Law K., Management of nonradicular neck pain in adults. Review current through June 2025. Last updated November 14, 2024. Available at: www.uptodate.com. Accessed July 2025. UpToDate. O'Connor FG., Mulvaney SW., Fields KB., et al. [Patellofemoral pain - UpToDate](#). Review current through June 2025. Last updated May 29, 2025. Available at: www.uptodate.com. Accessed July 2025.
31. UpToDate. Purdam CR., de Vos RJ, Fields KB., et al., [Tendinopathy: Overview of management - UpToDate](#) Review current through June 2025. Last updated February 27, 2025. Available at: www.uptodate.com. Accessed July 2025.
32. UpToDate. Taylor FR., Swanson JW., Law K., et al. Tension-type headache in adults: Preventative treatment. Review current through June 2025. Last updated July 1, 2025. Available at: www.uptodate.com. Accessed July 2025.
33. UpToDate. Barker LK, Elkadry E., Brubaker L. et al. Myofascial pelvic pain syndrome in females; Treatment. Review current through June 2025. Last updated January 11, 2023. Available at: www.uptodate.com. Accessed July 2025.
34. Hayes a symplr company, Health Technology Assessment. Dry Needling for Knee Osteoarthritis in Adults. Hayes Inc., June 29, 2023. Annual review June 30, 2025. Available at: www.hayesinc.com. Accessed July 2025.

35. Hayes a symplr company., Evidence Analysis Research Brief. Dry Needling of Painful Myofascial Trigger Points in Adults. Hayes Inc., November 15, 2022. Available at: www.hayesinc.com. Accessed July 2025.
36. Hayes a symplr company, Health Technology Assessment. Dry Needling for Mechanical Neck and/or Trapezius Muscle Pain in Adults. May 18, 2023. Annual Review June 30, 2025. Available at: www.hayesinc.com. Accessed July 2025.

CODES

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Place of Service	Outpatient	

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Date	Action	Action
July 2025	Annual Review	Policy Renewed
June 2024	Annual Review	Policy Renewed
June 2023	Annual Review	Policy Revised
November 2022	Annual Review	Policy Renewed
November 2021	Annual Review	Policy Revised
November 2020	Annual Review	Policy Revised

Date	Action	Action
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November 2018		New Policy

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