AOCPMR | American Osteopathic College of Physical Medicine & Rehabilitation

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Novitas LCD
VIA ProposedLCDComments@novitas-solutions.com

To Whom It May Concern:

I am writing to formally oppose the proposed LCD limitations on trigger point injections as currently drafted, and I do so not only as a physician but as a clinician who treated a patient just this week for whom trigger point injection is the only intervention that provides meaningful relief.

The proposed LCD states that "the routine performance of more than three (3) TPI sessions within a rolling 12-month period is not reasonable and necessary." As a physician who specializes in the diagnosis and interventional management of musculoskeletal pain, I find this limitation to be clinically indefensible, scientifically unsupported, and harmful to the patients I am entrusted to care for.

In my practice, it is not uncommon to treat patients who have exhausted pharmacological and non-pharmacological conservative management and who respond specifically and meaningfully to trigger point injections. These are patients who suffer. These are patients who function. And trigger point injection is frequently the only tool that bridges that gap.

Consider the following clinical scenario — one that reflects the reality of cervical and lumbar spine care: a patient develops a trigger point in the right upper trapezius in January, contributing to cervicogenic headache and cervical pain. In March, a trigger point develops in the left levator scapulae, generating referred pain along the cervical spine and scapular border. In May, a trigger point is identified in the right quadratus lumborum, producing unilateral low back pain with positional limitation. In July, a trigger point develops in the left iliopsoas, contributing to lumbar pain and restricted hip flexion with forward loading. Under the proposed LCD, the fourth injection — to the left iliopsoas — would be deemed "not reasonable and necessary." I ask sincerely: what does a trigger point injection to the right upper trapezius, left levator scapulae, or right quadratus lumborum have to do with the medical necessity of an injection to the left iliopsoas? These are anatomically distinct muscle groups, clinically independent presentations, and entirely separate indications. This rule defies basic clinical logic.

The LCD further proposes a cap of five TPI sessions per rolling 12-month period. In a patient with six active trigger points across six distinct cervical and lumbar muscle groups — one who has demonstrated a documented clinical response to TPI — this rule eliminates the possibility of treatment for the sixth trigger point entirely, regardless of its medical necessity and regardless of the patient's established responsiveness. Consider a sixth trigger point developing in the right multifidus or cervical paraspinals — muscles intimately involved in axial stability and a common pain generator in both cervical and lumbar spine pathology. Under this rule, that patient goes untreated. This is not medicine. This is rationing.

I want to be direct: these limitations provide cost savings. They do not serve the public interest. They are not supported by medical literature. Not one of the cited studies — nor any study in the peer-reviewed literature — has established that performing TPI in three muscle groups renders TPI to a fourth distinct muscle group unreasonable or unnecessary. Literature does not support a 12-month cap of five sessions when a sixth clinically distinct trigger point is identified. On the contrary, the medical literature consistently and unanimously demonstrates that when trigger point injection is performed for identified active trigger points, symptoms are alleviated.

These rules, as written, are scientifically unsupported, clinically harmful, and limit the ability of physicians to provide appropriate, evidence-based care to suffering patients. I urge the drafting body to reconsider these limitations and to ground future policy in clinical evidence rather than administrative convenience.

Respectfully submitted,

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President
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