INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Blue Cross Blue Shield of Rhode Island

Minimally Invasive Procedures for Back Pain Medical Policy

Blue Cross Blue Shield of Rhode Island has issued a coverage policy for the Intracept™ Procedure **effective 04/01/2026**. The policy outlines specific details regarding criteria and limitations to meet medical necessity.

The requirements should be adhered to closely and documented accordingly in the patient chart to ensure the patient meets medical necessity.

Coverage Criteria & Documentation Requirements:

Thermal destruction of the intraosseous basivertebral nerve (e.g., Intracept® system) will be considered medically reasonable and necessary for the treatment of chronic low back pain in patients who meet ALL the following criteria and do not meet any of the contraindications (#6) below:

☐ 1. Chronic lumbar back pain of ≥6 months duration that causes functional deficit measured on a pain or disability scale*; **and**

☐ 2. Documented failure to respond to ≥6 months of non-surgical management**; **and**

☐ 3. Absence of non-vertebrogenic pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity; **and**

☐ 4. Evidence of Type 1 or Type 2 Modic changes on MRI, such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypotensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hypertensive signals (Type 2 Modic change), in 1 or more vertebrae from L3-S1; **and**

☐ 5. Individuals must have undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to thermal destruction of the intraosseous BVN (such screening must include psychological, as well as, physical evaluation). Documentation of the history and careful screening must be available in the patient chart if requested; **and**

☐ 6. None of the following contraindications listed below are present at the time thermal destruction of the intraosseous basivertebral nerve (e.g., Intracept® system) is performed:

- Skeletally immature patients (≤18 years old);

- Severe cardiac or pulmonary compromise;
- Active systemic infection or local infection at the intended treatment level;
- Bleeding diathesis
- Pregnancy
- Primary radicular pain into the lower extremities (defined as nerve pain following a dermatomal distribution and that correlates with nerve compression on imaging)
- Previous lumbar/lumbosacral spine surgery at the intended treatment level (with the exception of discectomy/laminectomy if performed >6 months prior to BVN nerve ablation and radicular pain resolved);
- Primary symptomatic lumbar or lumbosacral spinal stenosis (defined as the presence of neurogenic claudication and confirmed by imaging);
- Diagnosed osteoporosis (T-score of -2.5 or less), spine fragility fracture history, trauma/compression fracture at the intended treatment level, or spinal cancer;
- Radiographic evidence of any of the following that correlates with predominant physical complaints:
    - Lumbar/lumbosacral disc extrusion or protrusion >5mm at levels L3-S1;
    - Lumbar/lumbosacral spondylolisthesis > 2mm at any level;
    - Lumbar/lumbosacral spondylolysis at levels L3-S1;
    - Lumbar/lumbosacral facet arthrosis/effusion correlated with facet-mediated pain at levels L3-S1.
- BMI >40;
- Advanced generalized systemic disease that limits quality-of-life (QOL) improvements would require a statement of the objective of treatment in such cases;
- Active, untreated substance abuse disorder
- Individual is a tobacco user OR there is no clinical documentation that the individual has been abstinent from tobacco use based on attestation.

NOTE: Thermal destruction of the intraosseous BVN must only be performed once per vertebral body from L3-S1 per lifetime. Up to 4 vertebral bodies may be treated during 1 procedure.

* Pain assessment and a disability scale must be obtained at baseline to be used for functional assessment.

** Non-surgical management may include but is not limited to:

- Avoidance of activities that aggravate pain;
- Trial of Chiropractic manipulation;
- Trial of Physical Therapy;
- Cognitive support and recovery reassurance;

- Injection therapy – epidural and/or facet;
- Spine biomechanics education;
- Specific lumbar exercise program;
- Home use of heat/cold modalities;
- Low impact aerobic exercise as tolerated;
- Pharmacotherapy (e.g., non-narcotic analgesics, NSAIDs, muscle relaxants, neuroleptics, and narcotics)

Coding:

CPT Code	Description
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies lumbar or sacral
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral

References:

2025 DRAFT Minimally Invasive Procedures for Back Pain.Effective.4.1.2026.pdf

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View Boston Scientific Intracept Intraosseous Nerve Ablation System Indications, Safety, and Warnings at bostonscientific.com/intracept-indications