INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
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Coverage Criteria Summary – Blue Cross Blue Shield of Vermont

Intrasseous Basivertebral Nerve Ablation (i.e., Intracept® System) Corporate Medical Policy

Blue Cross Blue Shield of Vermont has issued a coverage policy for the Intracept™ Procedure **effective 03/01/2026**. 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.

WHEN A SERVICE MAY BE CONSIDERED MEDICALLY NECESSARY:
Radiofrequency ablation of the basivertebral nerve, with an FDA cleared device, (i.e., Intracept® system), for one or more levels of L3 through S1, for the treatment of vertebrogenic back pain may be considered medically necessary when ALL of the following are met:

☐ 1. Individual is skeletally mature (≥ 18 years of age); **and**

☐ 2. Moderate to severe chronic low back pain that is primarily axial (definition below) in nature; **and**

☐ 3. Pain is refractory to at least 6 months of non-operative treatment (definition below) within the past year, including at least 6 weeks of detailed professional directed exercise program (i.e. Physical Therapy); **and**

☐ 4. Type 1 or Type 2 Modic changes are noted at the vertebral body(ies) to be treated, on an MRI between L3 and S1.
- Type 1 - inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypo-intensive signals; OR
- Type 2 - changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyper-intensive signals.

Definition of Axial Pain - Pain that is localized (e.g., lower back) and is not accompanied by motor or sensory dysfunction in the associated extremities (e.g. legs).

Definition of Non-Operative Treatment - Pharmacological therapy (e.g., analgesics, anti inflammatory drugs, muscle relaxants), exercise, spinal manipulation, acupuncture, cognitive-behavioral therapy, and physical therapy.

WHEN A SERVICE IS CONSIDERED INVESTIGATIONAL:
Radiofrequency ablation of the basivertebral nerve (e.g., Intracept® system) for the treatment of back pain is considered investigational when ANY of the following are present:

- Imaging suggests other etiologies for pain including: o Active or recurrent facet symptoms
  - Disc extrusion or protrusion (>5 mm)
  - Spondylolisthesis (>2 mm at any level) o Spondylolysis at any level
  - Lumbar scoliosis (> 10 degrees) o Modic changes at any level above L3-L4
- History of spine fragility fracture
- Osteoporosis (T-score < -2.5)
- Trauma/compression fracture
- Spinal cancer
- Imaging-confirmed spinal stenosis with neurogenic claudication (pain, numbness, and/or weakness into the buttocks, thighs, and/or calves, often brought on by standing or walking and relieved by flexion or sitting).
- Active or recurrent radicular pain (pain that travels along a dermatomal distribution into the lower extremity, which can be associated with numbness, weakness, and/or tingling).
- Any prior lumbar spine surgery, other than laminectomy or discectomy > 6 months prior with resolution of radiculopathy.
- Bed bound or other condition that prevent early mobility
- BMI > 40 • Presence of severe cardiac or pulmonary compromise
- Pregnancy, less than 12 months postpartum or current breast-feeding
- Active systemic infection, spine infection or bleeding diathesis
- Planned in conjunction with any other procedures, or within 6 weeks of any prior procedure
- Repeat basivertebral ablation at the same level as a previous basivertebral nerve ablation.
- In all other indications and/or when medical necessity criteria above are not met.

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:

Intraosseous Basivertebral Nerve Ablation (i.e., Intracept) - 2025 - Publication.pdf

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

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