INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
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Coverage Criteria Summary – BCBS of Nebraska

Intraosseous Radiofrequency Ablation of the Basivertebral Nerve for Chronic Low Back Pain #III.237 (i.e., Intracept™ Procedure)

BCBS of Nebraska issued a coverage policy for the Intracept® Procedure **effective 03/16/21**. 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:

The Intracept™ Procedure is currently the only procedure specifically cleared for the treatment of basivertebral nerve pain.

Intraosseous radiofrequency ablation of the basivertebral nerve is scientifically validated when all of the following are met:

- ☐ 1. Skeletally mature patients (age > 18 years old), AND
- ☐ 2. Chronic low back pain for at least 6 months, AND
- ☐ 3. Conservative measures tried and failed:
    a. At least 6 weeks of documented physical therapy AND
    b. At least 6 months of pharmacotherapy (narcotics, non-narcotic analgesics, muscle relaxants, neuroleptics, and/or anti-inflammatories) AND
- ☐ 4. MRI demonstrates Type 1 or Type 2 Modic changes at one or more vertebrae from L3 to S1, AND
- ☐ 5. Activities of daily living limited due to persistent low back pain

All other uses of intraosseous radiofrequency ablation are considered investigational.

Limitations:

- Skeletally immature patients (< 18 years old)
- Severe cardiac or pulmonary compromise
- Radicular pain
- Targeted ablation zone is <10mm away from sensitive structure not intended to be ablated, including the vertebral foramen
- Active systemic infection or local infection in the area to be treated
- Patients who are pregnant
- Skeletally immature patients (<18 years)
- Patients with implantable pulse generators (pacemakers, defibrillators) or other electron implants

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:

https://medicalpolicy.nebraskablue.com/Policy/430/3

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Indications for Use: The Intracept™ Intraosseous Nerve Ablation System is intended to be used in conjunction with radiofrequency (RF) generators for the ablation of basivertebral nerves of the L3 through S1 vertebrae for the relief of chronic low back pain of at least six months duration that has not responded to at least six months of conservative care, and is also accompanied by features consistent with Type 1 or Type 2 Modic changes on an MRI such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypointensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyperintensive signals (Type 2 Modic change). Contraindications - Use of the Intracept Intraosseous Nerve Ablation System is contraindicated in: Patients with severe cardiac or pulmonary compromise, patients with active implantable pulse generators (e.g. pacemakers, defibrillators), patients where the targeted ablation zone is < 10 mm away from a sensitive structure not intended to be ablated, including the vertebral foramen (spinal canal), patients with active systemic infection or local infection in the area to be treated, patients who are pregnant, and/or skeletally immature patients (generally ≤ 18 years of age). Refer to the Instructions for Use provided with the Intracept Procedure or www.relievant.com/intracept/ for potential adverse effects, warnings, and precautions prior to using this product.

Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

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