INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summaries – Care Source Commercial and Ohio Medicare-Medicaid Dual Eligible

Intraosseous Basivertebral Nerve Ablation No. MP-MM-1376 Commercial Plan

CareSource issued a commercial coverage policy for the Intracept™ Procedure effective **05/01/2025**. 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. Effective **08/01/2025**, Ohio Medicare-Medicaid Dual Eligible members have an additional documentation requirement noted in section 1a below.

Coverage Criteria & Documentation Requirements:

I. Basivertebral nerve ablation may be considered medically necessary when **ALL** of the following criteria have been met:

☐ 1. The member has a diagnosis and documentation of chronic low back pain of at least 6 months duration.
   a. For Medicare-Medicaid Dual Eligible members, documentation of chronic low back pain of at least 6 months duration that causes functional deficit measured on a pain or disability scale (such as VAS or ODI)

☐ 2. Failure of conservative therapy, as evidenced by **ALL** the following:
   a. Documentation in the medical record of at least 6 weeks of active conservative therapy* within the past 6 months **OR** inability to complete active conservative therapy due to contraindication, increased pain, or intolerance.
   b. Documentation in the medical record of at least 6 weeks of inactive conservative therapy** within the past 6 months.

**Actions or activities that strengthen muscle groups and target key spinal structures, including physical therapy, occupational therapy, physician supervised home exercise program (HEP), and/or chiropractic care.*

***Passive activities by the patient that aid in treating symptoms associated with pain, including rest, ice, heat, medical devices, TENS use, and/or pharmacotherapy (prescription or over the counter [e.g., non-steroidal anti-inflammatory drugs, acetaminophen]).*

☐ 3. MRI has been performed and demonstrates Type 1 or Type 2 Modic changes at one or more vertebral endplates from level L3 to S1, as demonstrated by:
   a. Hypointense T1-weighted signal and hyperintense T2-weighted signal (i.e., bone marrow edema and inflammation); **OR**
   b. Hyperintense T1-weighted signal and hyperintense T2-weighted signal (i.e., bone marrow ischemia).

(*continued on next page*)

☐ 4. The device is FDA-approved (e.g., Intracept System).[1]

☐ 5. The member does not have any of the following contraindications:
   a. Severe cardiac or pulmonary compromise
   b. Member has a targeted ablation zone less than 10mm from a sensitive structure not intended to be ablated (including vertebral foramen)
   c. Active systemic infection or localized infection in the area to be treated
   d. Current pregnancy
   e. Skeletal immaturity
   f. Implantable pulse generator (e.g., pacemaker, defibrillator) or other electronic implant[2]
   g. Scoliosis
   h. Spinal instability

II. Repeat or additional intraosseous basivertebral nerve ablation is not considered medically necessary, as it has not been adequately studied in the peer-reviewed medical literature.

III. Monitored anesthesia and conscious sedation during intraosseous basivertebral nerve ablation are considered not medically necessary and will therefore not be reimbursed.

IV. Coverage is limited to the above criteria. Intraosseous basivertebral nerve ablation is considered not medically necessary for all other indications.

1. *Please note that the Intracept System received FDA 510(k) clearance for the treatment of vertebrogenic chronic low back pain.*
2. *Please note that the Intracept System is only contraindicated in patients with **active** implantable pulse generators (e.g. pacemakers, defibrillators). See Indications for Use on next page for more information.*

CPT 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://www.caresource.com/documents/marketplace-oh-policy-medical-mm-1376-20250501

https://www.caresource.com/documents/dsnp-oh-policy-medical-mm-1723-20250801.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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