INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Health Care Service Corporation (HCSC)

Includes BCBS IL, MT, NM, OK, TX

Intraosseous Radiofrequency Nerve Ablation of the Basivertebral nerve for the Treatment of Low Back Pain

SUR702.020

HCSC has issued a coverage policy for the Intracept™ Procedure **effective 12/01/2025**. 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.

Coverage Criteria & Documentation Requirements:

Basivertebral Nerve Ablation is generally covered subject to the indications below and patient plan documents:

- ☐ 1. Skeletally mature (18 years of age or older); **AND**
- ☐ 2. Chronic low back pain (CLBP) for at least 6 months, and lower back pain is the main symptom; **AND**
- ☐ 3. Failure to adequately improve after six months of nonsurgical management (e.g., activity/lifestyle modification, physical therapy, medications [nonsteroidal anti-inflammatory drugs, nonnarcotic analgesics]); **AND**
- ☐ 4. Modic Type 1 or 2 changes seen on MRI – endplate hypointensity (Type 1) or hyperintensity (Type 2) on T1 images plus hyperintensity on T2 images (Type 1) in the endplates between L3 and S1.

Indications That Are Not Covered:

Intraosseous radiofrequency ablation of the basivertebral nerve (L3-S1 vertebrae) (e.g., Intracept® system) for the treatment of axial lower back pain that is of vertebrogenic nature is considered not medically necessary when ANY of the following are present:

1. Evidence on imaging (MRI, flexion/extension radiographs, etc.) suggests another obvious etiology for the individual's LBP symptoms, including but not limited to lumbar stenosis, spondylolisthesis, segmental instability, disc herniation, degenerative scoliosis or facet arthropathy, or effusion with clinically suspected facet joint pain.
2. Metabolic bone disease (e.g., osteoporosis), treatment of spine fragility fracture, trauma/ compression fracture, or spinal cancer.
3. Spine infection or active systemic infection.

4. Neurogenic claudication, lumbar radiculopathy, or radicular pain due to neurocompression (e.g., herniated nucleus pulposus (HNP), stenosis) as primary symptoms.
5. Severe cardiac or pulmonary compromise.
6. Individuals with implantable pulse generators (e.g., pacemakers, defibrillators) or other electronic implants unless specific precautions are taken to maintain patient safety.
7. Individual with BMI > 40.

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

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.hcsc.com/disclaimer?corpEntCd=HCSC

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