INTRACEPT™
Vertebrogenic Pain Relief

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Coverage Criteria Summary – Physician's Health Plan of Northern Indiana

Radiofrequency Ablation - Policy No. CLP 224.0

Physician's Health Plan of Northern Indiana issued a coverage policy for the Intracept™ Procedure effective **09/15/25**. 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:

Radiofrequency Nerve Ablation (eg: Intracept System) is considered medically necessary when **all** of the following criteria are met:

☐ 1. Ablation of Basivertebral nerves of the L3-S1 vertebrae; **and**

☐ 2. Chronic low back pain for at least 6 months duration that is refractory to at least 6 months of conservative care; **and**

☐ 3. MRI report is consistent with Type 1 and Type 2 Modic changes; **and**

☐ 4. Documentation supports <u>lack of the following contraindications:</u>

- Severe cardiac or pulmonary compromise
- The targeted ablation zone is less than 10 mm away from a sensitive structure not intended to be ablated (including the vertebral foramen)
- Active system infection or local infection in the treatment area
- Currently pregnant
- Skeletal immaturity (eg: < 18 years of age)
- Documentation of implanted pulse generator (eg: pacemaker, defibrillator) or other electronic implant

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

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References:

https://public.powerdms.com/PHPNI/documents/3494675

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

Boston Scientific Corporation | 7201 Metro Blvd #300 | Edina, MN 55439
P 650-368-1000