INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – BCBS of South Carolina
Intraosseous Radiofrequency Ablation (Intracept) Procedure – CAM 394

Blue Cross and Blue Shield of South Carolina issued a coverage policy for the Intracept™ Procedure effective **07/01/25**. 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.

Policy:

Intraosseous radiofrequency nerve ablation of the basivertebral nerve (i.e., Intracept™ Intraosseous Nerve Ablation System) is considered **MEDICALLY NECESSARY** for treatment of chronic, vertebrogenic low back for at least 12 months duration and at no more than three adjacent vertebral bodies (i.e., between L3-S1), during which time ALL of the following criteria have been met:

☐ 1. Unremitting back pain and significant functional impairment continues despite at least six consecutive months of structured*, physician supervised conservative medical management, including ALL of the following components:
   a. Exercise, including core stabilization exercises
   b. Nonsteroidal and/or steroidal medication (unless contraindicated)
   c. Physical therapy, including passive and active treatment modalities
   d. Activity/lifestyle modification
   e. Participation in 3 or more individual or group cognitive behavioral therapy (CBT) sessions provided by a licensed healthcare professional (e.g., physical therapist, [PT], occupational therapist [OT], psychiatrist, psychologist, social worker, psychiatric nurse, other licensed professional) with competence in principles and practice of CBT and providing individualized treatment that includes ALL of the following elements:
      i. Disease education
      ii. Activity and lifestyle modification
      iii. Stress management (stress management typically also includes strategies to deal with emotions such as fear, anxiety, sadness that can interfere with pain management); **AND**

☐ 2. Imaging studies confirm Modic Type I changes on MRI report (i.e., hypointense T1 and hyperintense T2 in the vertebral endplates) at a maximum of three vertebrae between L3 and S1) or Type I and Type II changes on MRI (hyperintense T1 and hyperintense T2 in the vertebral endplates) at a maximum of three vertebrae between L3 and S1); **AND**

☐ 3. Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider not involved with the recommended plan of treatment attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic back pain

***Note:** Structured medical management consists of medical care that is delivered through regularly scheduled appointments, including follow-up evaluation, with licensed healthcare professionals.

Intraosseous radiofrequency nerve ablation of the basivertebral nerve (i.e., Intracept Intraosseous Nerve Ablation System) is considered NOT MEDICALLY NECESSARY for any other indication, including the following:

- Metabolic bone disease (e.g., osteoporosis), treatment of spine fragility fracture, trauma/compression fracture or spinal cancer
- Spine infection or active systemic infection
- Neurogenic claudication, lumbar radiculopathy or radicular pain due to neurocompression (e.g., HNP, spinal stenosis), as primary symptoms
- Spondylolistheses > 2mm
- Disc protrusion > 5 mm
- Individuals with severe cardiac or pulmonary compromise
- Individuals with implantable pulse generators (e.g., pacemakers, defibrillators) or other electronic implants unless specific precautions are taken to maintain patient safety
- Treatment of other than L3-S1 vertebrae
- Treatment of more than three adjacent vertebral bodies (i.e., between L3-S1)
- Repeat treatment at the same level

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.southcarolinablues.com/web/public/brands/medicalpolicy/external/external-policies/intraosseous-radiofrequency-ablation-intracept-procedure/

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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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