INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – CareFirst BlueCross BlueShield
Policy #: 7.01.140 Intraosseous Basivertebral Nerve Ablation

CareFirst BlueCross BlueShield issued a coverage policy for the Intracept™ Procedure effective 05/01/2024. 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:

Intraosseous basivertebral nerve ablation is considered medically necessary for members who meet the below criteria:

☐ 1. The member has a diagnosis and documentation of chronic low back pain of at least sixmonths duration; AND

☐ 2. Documentation of unremitting back pain and significant functional impairment thatpersists despite at least six months of conservative treatment; AND

☐ 3. MRI has been performed and demonstrates Type 1 or Type 2 Modic changes at one ormore vertebral endplates from level L3 to S1.

Intraosseous basivertebral nerve ablation is considered **not medically necessary** when the above criteria are not met.

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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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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