INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Connecticare

Radiofrequency Ablation for Spinal Pain, Policy No. MG.MM.ME.39e
Intraosseous radiofrequency nerve ablation of the basivertebral nerve (i.e., Intracept™ Procedure)

Connecticare issued a coverage policy for the Intracept™ Procedure effective **02/14/25** for **Commercial and Medicare Advantage plans only**. 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 from L3 through S1 may be considered medically necessary in individuals 18 and over when **ALL** of the following criteria have been met:

- ☐ 1. Skeletal maturity; **AND**
- ☐ 2. Chronic lower back pain > 6 months; **AND**
- ☐ 3. Failure to respond to 3 months of conservative management (e.g. nonsteroidal anti-inflammatory/opioid medications, chiropractic therapy/physical therapy and a home exercise program; **AND**
- ☐ 4. Vertebrogenic back pain as evidenced by Type I or Type II Modic changes on MRI – endplate hypo-intensity (Type I) or hyperintensity (Type II) on T1 images plus hyperintensity on T2 images (Type 1) involving in the endplates between L3 and S1.

Limitations:

Members should have no history of spinal fusion surgery in the vertebral level being treated.

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

Diagnosis Codes:

There is a variety of diagnosis codes that may represent this patient population. Commonly used diagnosis codes for Intracept Procedure patients listed within this coverage policy include: M47.816, M47.817, M54.50.

INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

References:

https://www.connecticare.com/en/-/media/Project/PWS/Microsites/ConnectiCare/PDFs/Providers/Our-Policies/Medical/Commercial/radiofrequency-spinal-pain-medical-policy-connecticare.pdf

Disclaimer: Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label.

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

NM-2087410-AB