INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Geisinger
Intraosseous Basivertebral Nerve Ablation - Policy MP371

Geisinger issued a coverage policy for the Intracept™ Procedure effective **10/01/25**. 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.

Coverage Criteria & Documentation Requirements:

Basivertebral nerve ablation from L3 through S1 may be considered medically necessary when **ALL** of the following criteria have been met:

- ☐ 1. Member is skeletally mature (age > 18 years old); **and**
- ☐ 2. Chronic low back pain for at least 6 months; **and**
- ☐ 3. Failure to respond to at least 6 moths of conservative therapy (NSAIDs and/or acetaminophen; and physical therapy) with documentation of these types of treatments; **and**
- ☐ 4. MRI demonstrates Type 1 or Type 2 Modic changes* in at least one vertebral endplate at one or more vertebrae from L3 to S1; **and**
- ☐ 5. Activities of daily living limited due to persistent low back pain.

*There are 2 types of Modic changes found on Magnetic Resonance Imaging (MRI):

- **Type 1 –** Vascular development in the vertebral body, inflammation and edema, vertebral endplate changes, vascularized fibrous tissues within the adjacent marrow, hypointensive signals.
- **Type 2 –** Changes in the vertebral body's bone marrow including replacement of normal bone marrow by fat, and hyperintensive signals

Applicable Line of Business:

Commercial	**x**	**Medicaid**	**x**
Medicare	**x**	**ACA**	**x**
CHIP	**x**		

Exclusions:

The Plan considers the use of Intraosseous Basivertebral Nerve Ablation to be Unproven for any condition not meeting the criteria outlined above, including but not limited to, any of the following: lumbar stenosis, spondylolisthesis, segmental instability, disc herniation, degenerative scoliosis, or facet arthropathy or effusion with clinically suspected facet joint pain, metabolic bone disease (eg, osteoporosis), treatment of spine fragility fracture, trauma/compression fracture, history of or active spinal cancer, spine infection or active systemic infection, bleeding diathesis, neurogenic claudication, lumbar radiculopathy or radicular pain due to neurocompression. There is insufficient evidence in the published medical literature to support the efficacy of intraosseous basivertebral nerve ablation as a treatment for any of these conditions.

Limitations:

Repeat procedures will be considered at a frequency no sooner than 12 months.

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.geisinger.org/-/media/OneGeisinger/Files/Policy-PDFs/MP/351-400/MP371-Intraosseous-Basivertebral-Nerve-Ablation.pdf?sc_lang=en&hash=DBC9C6000FA280C123F7A532BEC146A1

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

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