INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Health Alliance Plan (HAP) CareSource

Intraosseous Basivertebral Nerve Ablation Procedure (i.e., Intracept™ Procedure)

HAP CareSource issued a coverage policy for the Intracept™ Procedure for HAP members **effective 08/01/25.** 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.

Definitions:

- **Conservative Therapy** – A multimodality plan of care including both active and inactive conservative therapies.
    - **Active Conservative Therapies** – Actions or activities that strengthen muscle groups and target key spinal structures, including physical therapy, occupational therapy, physician supervised home exercise program (HEP), and/or chiropractic care.
        - **HEP** – A 6-week program requiring an exercise prescription and/or plan and a follow-up documented in the medical record after completion, or documentation of the inability to complete the HEP due to a stated physical reason (ie, increased pain, inability to physically perform exercises). Patient inconvenience or noncompliance without explanation does not constitute an inability to complete.
    - **Inactive Conservative Therapies** – Passive activities by the patient that aid in treating symptoms associated with pain, including rest, ice, heat, medical devices, TENS use, and/or pharmacotherapy (prescription or over the counter [eg, non-steroidal anti-inflammatory drugs, acetaminophen]).
        - **Transcutaneous Electrical nerve Stimulator (TENS)** – a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. Its use, frequency, duration, and start dates must be documented in the medical record to be considered part of the conservative therapy during the period or prior authorization.

Coverage Criteria & Documentation Requirements:

Intraosseous ablation of the basivertebral nerve (such as: Intracept™ Intraosseous Nerve Ablation System) is covered for HAP members when **ALL** the following criteria are met:

☐ 1. Member has a diagnosis and documentation of chronic low back pain of at

least 6 months duration that causes functional deficit measured on a pain or disability scale.

☐ 2. Failure of conservative therapy, as evidenced by **ALL** the following:
   a. Documentation in the medical record of at least 6 weeks of active conservative therapy (see definition above) within the past 6 months OR inability to complete active conservative therapy due to contraindication, increased pain, or intolerance
   b. Documentation in the medical record of at least 6 weeks of inactive conservative therapy (see definition above) within the past 6 months

☐ 3. MRI demonstrates Type I or Type II modic changes at one or more vertebral endplates from level L3 to S1, as demonstrated by
   a. Hypointense T1-weighted signal and hyperintense T2-weighted signal (ie, bone marrow edema and inflammation), or
   b. Hyperintense T1-weighted signal and hyperintense T2-weighted signal (ie, bone marrow ischemia)

☐ 4. Device is FDA-approved (eg, Intracept System)*

☐ 5. Member does not have any of the following contradictions:
   a. Severe cardiac or pulmonary compromise
   b. Targeted ablation zones less than 10mm from a sensitive structure not intended to be ablated (including vertebral foramen)
   c. Active systemic infection or localized infection in the area to be treated
   d. Current pregnancy
   e. Skeletal immaturity
   f. Scoliosis
   g. Spinal instability

*FDA-approved is the verbiage used in the HAP published policy. The Intracept System is FDA-cleared.

Limitations:

1. Repeat or additional intraosseous basivertebral nerve ablation is not considered medically necessary, as it has not been adequately studied in peer-reviewed medical literature.

2. Monitored anesthesia and conscious sedation during intraosseous basivertebral nerve ablation are considered not medically necessary and will, therefore, not be reimbursed.

3. Coverage is limited to the above criteria. Intraosseous basivertebral nerve ablation is considered not medically necessary for all other indications.

INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

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:

mmp-mi-policy-medical-mm-1571-20250801.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