INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Highmark BCBS
Basivertebral Nerve Ablation #Z104-004
(i.e., Intracept™ Procedure)

Highmark BCBS issued a coverage policy for the Intracept™ Procedure **effective 03/04/2024.** 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:

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

- ☐ 1. The individual is skeletally mature; **and**
- ☐ 2. The individual has chronic low back pain of at least six (6) months duration; **and**
- ☐ 3. The individual has failed to respond to at least six (6) months of conservative treatment; **and**
- ☐ 4. The individual's MRI demonstrates Modic changes one (1)(MC1) or Modic two (2)(MC2) in at least one (1) vertebral endplate at one (1) or more levels from L3 through S1.

Limitations:

The individual must receive at least 51% or greater benefit from the basivertebral nerve ablation prior to repeat procedure.

More than two (2) basivertebral nerve ablations per benefit year will be considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Basivertebral nerve ablation not meeting the criteria as indicated in this policy is considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

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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:

M47.816, M47.817, M51.36, M51.37, M54.50, M54.51, M54.59

References:

https://securecms.highmark.com/content/medpolicy/en/highmark/pa/commercial/policies/Miscellaneous/Z-104/Z-104-004.html

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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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