INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Mass General Brigham Medical Policy

Basivertebral Nerve Ablation - Policy 076

Mass General Brigham Health Plan issued a coverage policy for the Intracept™ Procedure 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.

Coverage Guidelines:

Mass General Brigham Health Plan considers BVNA at levels L3 to S1 **medically necessary** for the treatment of chronic lower back pain of vertebrogenic origin when ALL of the following criteria are met:

- ☐ 1. Member is 25 years of age or older;
- ☐ 2. Chronic lower back pain has persisted for at least six months;
- ☐ 3. Pain has failed to adequately improve despite six months of non-operative management, including:
  a. At least 4 weeks of physical therapy, and
  b. At least 4 weeks of acetaminophen and/or NSAIDs, and
  c. Activity and/or lifestyle modification.
- ☐ 4. MRI evidence of Modic Type 1 or Type 2 changes involving the endplates between L3 and S1.
- ☐ 5. If disc extrusion or protrusion >5mm is present in the lumbar spine, epidural steroid injection has been performed within the past 2 years and resulted in <50% symptom improvement
- ☐ 6. If facet arthrosis/effusion is present, and pain increases with facet loading maneuvers, then 2 diagnostic facet joint injections or medial nerve blocks have been performed within the past 2 years and resulted in <50% symptom improvement

Exclusions:

Mass General Brigham Health Plan considers BVNA **experimental and investigational** when any of the following conditions is present:

- Radicular pain,
- Previous lumbar spine surgery,
- Symptomatic spinal stenosis,
- Spine infection or other active systemic infection,
- Osteoporosis, metabolic bone disease, or history of spine fragility fracture
- Vertebral fracture within the past year,
- Malignancy of the spine,
- Spondylolisthesis >2 mm,
- Spondylolysis at any level,
- Severe cardiac or pulmonary disease,
- BMI >40,
- Poorly controlled major psychiatric disease that is suspected to be a major contributor to back pain,
- Bedbound or a neurologic condition that prevents early mobility,
- Pregnancy,
- Treatment of vertebrae above L3 or below S1,
- Repeat BVNA on a vertebra that has previously been treated with BVNA

Additionally, BVNA is considered **experimental and investigational** when performed concurrently with other procedures, including steroid injections, nerve blocks, ablation of other nerves, and surgeries.

Medicare Variation:

Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for coverage determinations.

At the time of Mass General Brigham Health Plan's most recent policy review, CMS includes the following coverage guidelines:

- LCD: Intraosseous Basivertebral Nerve Ablation (L39642)
- LCD: Intraosseous Basivertebral Nerve Ablation (L39644)
- LCD: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (L39420)

When NCDs are not available, and LCDs are not available for the states in which Mass General Brigham Health Plan members seek care, Mass General Brigham Health Plan applies additional coverage criteria to clarify medical necessity of the requested service. Mass General Brigham Health Plan coverage criteria align with the latest clinical evidence and accepted standards of practice, without contradicting existing determinations, and enhance the clarity of medical necessity criteria, documentation requirements, and clinical indications. For members who do not seek care in the states covered by the LCDs above, Mass General Brigham Health Plan uses the criteria described in this policy to review requests for BVNA.

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

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