INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
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Coverage Criteria Summary – Priority Health

Neuroablation for Pain Management No. 91647-R0

Intraosseous radiofrequency nerve ablation of the basivertebral nerve (i.e., Intracept™ Procedure)

Priority Health issued a coverage policy for the Intracept™ Procedure **effective 09/01/24**. 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. Please review the coverage policy in its entirety.

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. Ablation of basivertebral nerves of the L3 through S1 vertebrae, **AND**
- ☐ 2. Chronic low back pain of at least six months duration that has not responded to at least six months of conservative case, **AND**
- ☐ 3. MRI evidence consistent with Type I or Type 2 Modic changes, **AND**
- ☐ 4. None of the contraindications listed below:
    a. Severe cardiac or pulmonary compromise.
    b. The targeted ablation zone is less 10 mm away from a sensitive structure not intended to be ablated, including the vertebral foramen (spinal canal).
    c. Active systemic infection or local infection in the area to be treated.
    d. Currently pregnant.
    e. Skeletally immature patients (generally < 18 years of age).
    f. Has implantable pulse generators (e.g., pacemakers, defibrillators) or other electronic implants.

Limitations:

a) For the purposes of this policy, an RFA procedure consists of one or more ablations during a single visit.
b) RFA procedures are limited to two per year.
c) RFA procedures beyond two per year require medical review.
d) RFA of the sacroiliac (SI) joint is not medically necessary.

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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

References:

See “Neuroablation for Pain Management” policy at:
https://beta.priorityhealth.com/provider/manual/medical-policies

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

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