network health

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Basivertebral Nerve Ablation – Intracept Procedure Medical Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) utilization management (UM) team, applies review guidelines for determinations involving medical necessity review for Basivertebral nerve (BVN) ablation (i.e., Intracept procedure). BVN ablation is intended to reduce or relieve pain associated with chronic vertebrogenic low back pain.

Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, or Individual and Family Plan to determine eligibility and coverage because Employer Group/Plan Sponsor and government contracts may vary. NHIC follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership. In the absence of a Medicare LCD/NCD Network Health will use this internal policy criteria for medical necessity determinations for Medicare Advantage membership.

I. Description

A. Basivertebral nerve (BVN) ablation, also known as the Intracept procedure, is a minimally invasive spinal procedure, performed in the outpatient or ambulatory setting. A cannula is inserted through the vertebral body to the trunk of the basivertebral nerve. A probe is then inserted through the cannula and radiofrequency energy is delivered to destroy or "ablate" the nerve and provide reduction or relief of chronic vertebrogenic low back pain.

II. Medical Indicators/Criteria

A. In the absence of Centers for Medicare & Medicaid Services (CMS) published National Coverage Determination (NCD) or Local Coverage Determination (LCD) providing coverage indications for this region, Network Health utilizes the CMS published criteria under LCD Intraosseous Basivertebral Nerve Ablation L39644 for coverage guidance of medical necessity determinations for the Intracept procedure for all Medicare lines of business.

B. In the absence of MCG published clinical guidelines, Network Health utilizes the CMS published criteria under LCD Intraosseous Basivertebral Nerve Ablation L39644 for coverage guidance of medical necessity determinations for

the Intracept procedure for all Commercial lines of business.

III. Coverage

A. Network Health follows the clinical guidance of LCD Intraosseous Basivertebral Nerve Ablation L39644 for coverage indications, contraindications, definitions, and limitations for BVN ablation. BVN ablation (i.e., Intracept procedure) is a covered benefit when determined to be medically necessary per the criteria indicated above.

IV. Limitations/Exclusions

A. BVN ablation (i.e., Intracept procedure) will be denied as not medically necessary for individuals who have limitations or contraindications for the procedure, or who do not meet the coverage indications per LCD Intraosseous Basivertebral Nerve Ablation L39644.

B. BVN ablation (i.e., Intracept procedure) exceeding the limitations as outlined in LCD Intraosseous Basivertebral Nerve Ablation L39644 will be denied as not reasonable or medically necessary.

C. The use of BVN ablation (i.e., Intracept procedure) for any indication, other than outlined in LCD Intraosseous Basivertebral Nerve Ablation L39644, will be reviewed under the NHP/NHIC/NHAS experimental, investigational and/or unproven process.

Regulatory Citations:

UM2

Related Documents:

None

CPT Codes*

64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	Each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure
*CPT codes are subject to change as codes are retired or new ones developed, the cpt codes list may not be all inclusive.	

References:

A. CMS, Local Coverage Determination (LCD) Intraosseous Basivertebral Nerve Ablation (L39644)
B. CMS, LCD Reference Article, Billing and Coding Article, Billing and Coding: Intraosseous Basivertebral Nerve Ablation (A59468)

C. Conger A, Burnham TR, Clark T, Teramoto M, McCormick ZL. The Effectiveness of Intraosseous Basivertebral Nerve Radiofrequency Ablation for the Treatment of Vertebrogenic Low Back Pain: An Updated Systematic Review with Single-Arm Meta-analysis. Pain Med. 2022 Jul 20;23(Suppl 2):S50-S62. doi: 10.1093/pm/pnac070. PMID: 35856331; PMCID: PMC9297160
D. Nwosu M, Agyeman WY, Bisht A, Gopinath A, Cheema AH, Chaludiya K, Khalid M, Yu AK. The Effectiveness of Intraosseous Basivertebral Nerve Ablation in the Treatment of Nonradiating Vertebrogenic Pain: A Systematic Review. Cureus. 2023 Apr 4;15(4):e37114. doi: 10.7759/cureus.37114. PMID: 37034146; PMCID: PMC10075185.
E. Sayed D, Naidu RK, Patel KV, Strand NH, Mehta P, Lam CM, Tieppo Francio V, Sheth S, Giuffrida A, Durkin B, Khatri N, Vodapally S, James CO, Westerhaus BD, Rupp A, Abdullah NM, Amirdelfan K, Petersen EA, Beall DP, Deer TR. Best Practice Guidelines on the Diagnosis and Treatment of Vertebrogenic Pain with Basivertebral Nerve Ablation from the American Society of Pain and Neuroscience. J Pain Res. 2022 Sep 14;15:2801-2819. doi: 10.2147/JPR.S378544. PMID: 36128549; PMCID: PMC9482788.
F. Schnapp W, Martiatu K, Delcroix GJR, et al. Basivertebral nerve ablation for the treatment of chronic low back pain: A scoping review of the literature. Pain Physician. 2022;25(4):E551-E562.
G. Fischgrund, J.S., Rhyne, A., Macadaeg, K. *et al.* Long-term outcomes following intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: 5-year treatment arm results from a prospective randomized double-blind sham-controlled multi-center study. *Eur Spine J* **29**, 1925–1934 (2020). https://doi.org/10.1007/s00586-020-06448-x
H. Fischgrund, J.S., Rhyne, A., Franke, J. *et al.* Intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: a prospective randomized double-blind sham-controlled multi-center study. *Eur Spine J* **27**, 1146–1156 (2018). https://doi.org/10.1007/s00586-018-5496-1

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e., Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov. Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only. Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

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