MASSACHUSETTS

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Prior Authorization Request Form for Intraosseous Basivertebral Nerve Ablation (Intracept® System) #486

Medical Policy #485 Intraosseous Basivertebral Nerve Ablation (Intracept® system)

Please use this form to assist in identifying members who meet Blue Cross Blue Shield of Massachusetts' (BCBSMA's) medical necessity criteria for Intraosseous Basivertebral Nerve Ablation (Intracept® system). For members who do not meet the criteria, submit a letter of medical necessity with a request for Clinical Exception (Individual Consideration).

Once completed, please fax to: This form must be completed and faxed to: Medical and Surgical: 1-888-282-0780; Medicare Advantage: 1-800-447-2994.

CLINICAL DOCUMENTATION
Copies of clinical documentation that supports the medical necessity criteria for Intracept® system must be submitted with this form. If the patient does not meet all the criteria listed below, please submit a letter of medical necessity explaining why an exception is justified.

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Place of Service: Outpatient ❒ Inpatient ❒ Distributor:

Physician Information	**Facility Information**
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

Please check off that the patient meets ALL the following criteria:	
Chronic lower back pain >6 months	❒
Refractory to optimal nonsurgical medical management including but not limited to physical therapy and chiropractic therapy, epidural or facet injection therapy, lumbar exercise and low impact exercise programs, home use of heat/cold therapies, pharmacotherapy, cognitive support and recovery assurance	❒
Modic type I or II changes on MRI, endplate hypointensity (Type 1) or hyperintensity (Type 2) on T1 images plus hyperintensity on T2 images (Type 1) involving in the endplates between L3 and S1 as evidenced by inflammation, edema, disruption, and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, and changes to the vertebral body marrow including replacement of normal bone marrow by fat.	❒

CONTRAINDICATIONS

Please check off that the patient DOES NOT HAVE ANY of the following contraindications:	

Individual does not have any of the following:
• Evidence on imaging (MRI, flexion/extension radiographs, etc.) indicating that pain may be due to another condition including but not limited to lumbar stenosis, spondylolisthesis, segmental instability, disc herniation, degenerative scoliosis, or facet arthropathy or effusion with clinically suspected facet joint pain, **or**
• Metabolic bone disease (eg, osteoporosis), treatment of spine fragility fracture, trauma/compression fracture, **or**
• History of or active spinal cancer, **or**
• Spine infection or active systemic infection, **or** |
• Bleeding diathesis, **or**
• Neurogenic claudication, lumbar radiculopathy or radicular pain due to neurocompression (eg, HNP, stenosis), as primary symptoms, **or**
• Radiographic evidence of:
  ○ Lumbar/lumbosacral disc extrusion or protrusion >5mm at levels L3-S1;
  ○ Lumbar/lumbosacral spondylolisthesis > Grade 2 at any level;
  ○ Lumbar/lumbosacral spondylolysis at levels L3-S1;
  ○ Lumbar/lumbosacral facet arthrosis/effusion correlated with facet-mediated pain at levels L3-S1
• Patients with severe cardiac or pulmonary compromise, **or**
• Patients with implantable pulse generators (eg, pacemakers, defibrillators) or other electronic implants unless, **or**
• Pregnancy, **or**
• BMI >40.
	❒

Providers should enter the relevant diagnosis code(s) below:

Code	Description	
64628	Thermal destruction of intraosseous basivertebral nerve, first 2 vertebral bodies	❒
64629	Thermal destruction of intraosseous basivertebral nerve, each additional vertebral body	❒

Providers should enter other relevant code(s) below:

Code	Description	
		❒
		❒