CareSource

MEDICAL POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Intraosseous Basivertebral Nerve Ablation-MP-MM-1376	11/01/2026 IN, OH, WV inactive as of 01/01/2027
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

This policy applies to the following Marketplace(s):			
☒ **Georgia**	☒ **Indiana**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Intraosseous Basivertebral Nerve Ablation

B. Background

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by providers qualified to deliver these health services.

Chronic low back pain (CLBP) is a common disabling condition, estimated to afflict 80% of adults at some point. Degenerative disc disease (DDD) is an important cause of CLBP. While discs are avascular with limited nerve distribution, vertebral endplates have the potential to trigger a cascade of degenerative events if there is a loss of integrity. Vertebral endplates are a thin interface between bone marrow and discs and contain neural elements. Breakdown of the endplate is believed to cause vertebrogenic chronic low back pain, a type of chronic low back pain. Endplate degeneration can be observed on MRI through Modic changes (MC). Type 1 MC reflect bone marrow edema and inflammation while Type 2 MC represent fatty marrow replacement.

Intraosseous basivertebral nerve ablation (BVNA) is a minimally invasive, image-guided procedure that uses radiofrequency energy to thermally ablate the basivertebral nerve within the vertebral body. The procedure is intended to interrupt nociceptive signaling from the vertebral endplates in individuals with vertebrogenic low back pain.

C. Definitions

- **Chronic Low Back Pain** – Persistent pain in the lumbar region lasting for more than 12 weeks.
- **Conservative Therapy** – A multimodality plan of care including both active and inactive conservative therapies.
  - **Active Conservative Therapies** – Actions or activities that strengthen muscle groups and target key spinal structures, including physical therapy, occupational therapy, physician supervised home exercise program (HEP), and/or chiropractic care.
    - **HEP** – A prescribed plan that includes specific goals, frequency, and expected duration, along with a clearly defined timeframe for reassessment (eg, 6 – 12 weeks). Ongoing continuation must be supported by documented clinical progress. Patient inconvenience or noncompliance without explanation does not constitute an inability to complete.
  - **Inactive Conservative Therapies** – Passive activities by the patient that aid in treating symptoms associated with pain, including rest, ice, heat, medical devices, Transcutaneous Electrical Nerve Stimulator (TENS) use, and/or pharmacotherapy (prescription or over the counter [eg, non-steroidal anti-inflammatory drugs, acetaminophen]).

- **Modic Changes** – Vertebral bone marrow signal intensity changes that are observable on MRI and are commonly associated with degenerative disc disease.
  - **Modic Change Type 1** – Characterized by hypo- intensive signals on T1-weighted images (T1WI) and hyper-intense signals on T2-weighted images (T2WI).
  - **Modic Change Type 2** – Characterized by hyper-intense signal intensities on both T1WI and T2WI.
  - **Modic Change Type 3** – Characterized by hypo-intense signal intensities on both T1WI and T2WI.

D. Policy

I. CareSource considers intraosseous basivertebral nerve ablation (BVNA) medically necessary when **ALL** the following clinical criteria are met:

A. Member has a diagnosis and documentation of low back pain of at least 6 months duration.

B. Pain is localized primarily to the lumbar spine without predominate radicular symptoms.

C. Failure of conservative therapy, as evidenced by documentation in the medical record of at least 6 weeks of active and inactive conservative therapy (see definition above) within the past 6 months OR inability to complete active conservative therapy due to contraindication, increased pain, or intolerance

D. MRI has been performed and demonstrates Type 1 or Type 2 Modic changes at one or more vertebral endplates from level L3 to S1.

E. Clinical evaluation demonstrates that the member's pain is not primarily attributable to other pain generators, such as symptomatic facet arthropathy, symptomatic lumbar spinal stenosis, or sacroiliac joint dysfunction.

F. Device is FDA-approved (eg, Intracept System).

G. Member does not have any of the following contraindications:

1. severe cardiac or pulmonary compromise
2. active systemic infection or localized infection in the area to be treated
3. current pregnancy
4. skeletal immaturity
5. implantable electronic devices that cannot be safely managed or deactivated during the procedure (eg, pacemaker, defibrillator)
6. spinal abnormality or anatomic considerations that may preclude safe access to the ablation site (eg, malignancy, sensitive structure not intended to be ablated)

II. Repeat or additional intraosseous BVNA is not considered medically necessary, as it has not been adequately studied in the peer-reviewed medical literature.

III. Monitored anesthesia and conscious sedation during intraosseous BVNA are considered not medically necessary and will therefore not be reimbursed.

IV. Coverage is limited to the above criteria. Intraosseous BVNA is considered not medically necessary for all other indications.

E. State-Specific Information
NA

F. Conditions of Coverage
NA

G. Related Policies/Rules
Sacroiliac Joint Procedures
Transcutaneous Electrical Nerve Stimulators

H. Review/Revision History

	DATE	ACTION
Date Issued	01/04/2023	New policy
Date Revised	06/07/2023	Annual review: reorganized conservative therapy, updated references. Approved at Committee.
	01/31/2024	Annual review: updated references and formatting. Approved at Committee.
	01/29/2025	Review: updated references, approved at Committee.
	12/17/2025	Review: updated references. Approved at Committee.
	08/12/2026	Review: updated HEP and Modic definitions; clarified pain criteria in section D.I.D & E; updated contraindications and Background. Approved at Committee.
Date Effective	11/01/2026	
Date Archived		

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