



February 27, 2026

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Submitted via: [NGSDraftLCDComments@anthem.com](mailto:NGSDraftLCDComments@anthem.com)

**Re: Public Comment for Proposed LCD - Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (DL40302)**

Dear Drs. Duerden and Boren,

The Society of Interventional Radiology (SIR) and the American College of Radiology (ACR) appreciate the opportunity to provide comments on the proposed Local Coverage Determination (LCD) related to thermal destruction of the intraosseous basivertebral nerve (BVN) for vertebrogenic lower back pain. As medical specialty societies representing over 40,000 members, including U.S. physicians practicing in vascular and interventional radiology, the SIR and ACR are committed to advancing high-quality, image-guided, minimally invasive care that reduces reliance on opioids and improves patient outcomes.

### **Redundant and Overlapping Policy Language**

The LCD repeats nearly identical clinical language regarding chronic low back pain, vertebrogenic pain characteristics, vertebral body endplate degeneration, and Modic changes in both the *Issue Description* and *Coverage Guidance* sections. This duplication blurs the line between background context and enforceable coverage criteria, potentially leading to inconsistent interpretation during claims review or audits. **SIR and ACR Recommendation:** Clearly distinguish descriptive background information from enforceable coverage criteria to reduce confusion and improve consistency.

### **Specification in Coverage Guidance of One Proprietary Technology**

The LCD specifically cites one proprietary device in the Coverage Guidance: Intracept. Moreover, it specifies a specific thermal ablation technology (radiofrequency) as well as a certain energy and time. As new technology is developed for thermal ablation of the basivertebral nerve, this LCD may unintentionally restrict the use of these new technologies. **SIR and ACR Recommendation:** Remove any reference to specific proprietary devices, specific thermal modalities (e.g., radiofrequency ablation), and any technology-specific parameters, including energy levels or duration settings.

### **Conservative Management Requirements Are Overly Rigid**

The LCD requires patients to have  $\geq 6$  months of pain and  $\geq 6$  months of non-surgical management, listing multiple therapies including physical therapy, chiropractic manipulation, injections, pharmacotherapy, and activity modification. The LCD does not specify that not all modalities need to be completed. This

may delay access to care and unnecessarily prolong patient suffering. **SIR and ACR Recommendation:** Clarify that conservative management should be individualized and clinically appropriate rather than exhaustive. Shorten the required duration of conservative management to **6 weeks** (a time more in line with other LCDs for pain interventions such as epidural steroid injection and facet interventions and supported by some studies showing that BVNA is effective even when including patients with a shorter duration of conservative management)<sup>1,2</sup>. Clarify that the minimum duration of conservative management does not begin after the minimum duration of symptoms but can occur simultaneously.

### **Multidisciplinary and Psychological Screening Requirements**

The LCD mandates that patients undergo evaluation by a multidisciplinary team, including psychological assessment, prior to BVNA. The LCD does not define “multidisciplinary team” or standardize the scope of psychological evaluation. These requirements exceed those for comparable interventional spine procedures, increase administrative burden, and may limit access in rural or underserved areas. No evidence is cited demonstrating improved outcomes resulting from these requirements. **SIR and ACR Recommendation:** Provide clear definitions and allow clinicians to exercise judgment regarding the need for multidisciplinary evaluation and psychological assessment based on patient-specific needs and available resources.

### **Modic Change Imaging Criteria May Be Overly Prescriptive**

The LCD provides highly detailed descriptions of Type 1 and Type 2 Modic changes on magnetic resonance imaging (MRI), specifying marrow signal alterations and endplate findings. Variability in radiology reporting could lead to inappropriate denials despite clinically appropriate findings. Often, radiology reports may not specifically describe endplate or Modic changes even when present. **SIR and ACR Recommendation:** Explicitly allow the treating physician’s interpretation of the MRI, supplemented by the radiology report, to determine eligibility for BVNA.

### **Imaging-Based Exclusions May Exclude Appropriate Patients**

Exclusion criteria based on disc protrusion size, facet arthrosis, spondylolisthesis, and other degenerative findings may inadvertently exclude patients whose primary pain is vertebrogenic, as these imaging findings are common, often incidental, and are very frequently seen in patients with Modic changes that are significant pain generators<sup>3,4</sup>. The LCD provides insufficient emphasis on clinical correlation between imaging findings and the patient’s predominant pain generator. **SIR and ACR Recommendation:** Ensure that imaging-based exclusions are applied in the context of clinical correlation to vertebrogenic pain, rather than relying solely on radiographic abnormalities.

### **Body Mass Index (BMI) >40 Exclusion Lacks Evidence**

The LCD imposes an absolute cutoff at BMI >40, without evidence that BVNA is less safe or less effective in this population. This criterion may unnecessarily deny access to patients who could benefit. **SIR and ACR Recommendation:** Remove or revise the BMI threshold unless supported by outcome-based evidence.

### **Lifetime Treatment Limitation**

The LCD restricts BVNA to once per vertebral body per lifetime. This limitation does not account for technical failure, incomplete ablation, or future clinical advancements, and may prevent appropriate

retreatment when clinically indicated. **SIR and ACR Recommendation:** Allow flexibility for retreatment in cases of technical failure or when new evidence demonstrates clinical benefit.

### Other Exclusion Criteria

Several additional exclusion criteria in the LCD lack evidence-based justification:

- Active substance use disorder: No evidence suggests these patients would not benefit; BVNA may reduce opioid dependence by treating a real pain generator.
- Advanced systemic illness: The LCD does not define this term and unnecessarily burdens clinicians to provide a statement of treatment objective, potentially excluding patients who could benefit.
- Previous lumbar/lumbosacral spine surgery at the intended level: Patients can still benefit from BVNA and could otherwise face unnecessary, morbid revision surgery<sup>5</sup>.

**SIR and ACR Recommendation:** Revise these exclusion criteria to reflect evidence-based guidance and allow individualized clinical judgment.

### Options for Patients Who Cannot Undergo MRI

Some patients cannot undergo MRI due to contraindications. For these patients, alternative imaging modalities, such as nuclear medicine bone scans, have been validated as effective imaging techniques to assess eligibility for BVNA<sup>2</sup>. **SIR and ACR Recommendation:** Include alternative imaging options to ensure access for patients who cannot undergo MRI.

**In conclusion**, BVNA is an important, evidence-based treatment for vertebrogenic chronic low back pain. However, multiple aspects of the current LCD, such as redundant language, rigid conservative management requirements, prescriptive imaging and exclusion criteria, undefined multidisciplinary and psychological evaluation requirements, overly restrictive BMI and lifetime limits, and lack of alternatives for patients unable to undergo MRI, may limit access to care, create unnecessary administrative burden, and restrict physician judgment. The Society of Interventional Radiology respectfully recommends that the LCD be revised to emphasize patient-centered, evidence-based care, allow individualized clinical decision-making, and focus on functional outcomes rather than rigid, prescriptive requirements. These changes would ensure Medicare beneficiaries have timely access to safe and effective BVNA.

We appreciate the opportunity to provide meaningful feedback on the NGS proposed LCD for Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain. If you have any questions, please do not hesitate to contact SIR's Senior Manager of Health Policy and Economics, Ashley Maleki, at [amaleki@sirweb.org](mailto:amaleki@sirweb.org) or (703) 844-0378.

Sincerely,



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American College of Radiology

Cc: Eve Lee, MBA, CAE  
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