

# Medtronic

# Basivertebral Nerve Ablation (BVNA)

2026 coding and payment guide

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# ICD-10-CM diagnosis codes

Hospitals and other providers assign ICD-10-CM codes to indicate a patient's diagnosis or clinical status. The following is a list of examples of possible ICD-10-CM diagnosis codes that may relate to indications associated with Basivertebral Nerve Ablation (BVNA) procedures. This is not an all-inclusive list and the diagnosis codes reported should be based on documentation appropriate to individual patient presentation. Refer to the Instructions for Use supplied with a product for indications, contraindications, side effects, warnings, and precautions.

ICD-10-CM code <sup>1,2,3</sup>	Description
<b>M54.51</b>	Vertebrogenic low back pain
<b>M47.816</b>	Spondylosis without myelopathy or radiculopathy, lumbar region
<b>M47.817</b>	Spondylosis without myelopathy or radiculopathy, lumbosacral region

# HCPCS II device codes

## Device C-codes

For Outpatient Hospitals, code C1886 may be used to report the ablation catheter device [probe], in addition to the CPT code for the ablation procedure.

HCPCS II device codes <sup>4</sup>	HCPCS II code description
<b>C1886</b>	Catheter, extravascular tissue ablation, any modality (insertable)

The device C-code above is applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, [click here for a C-code finder](#) or search by model number, product name, C-code, C-code description, or product category.

# Physician coding and payment

January 1, 2026 - December 31, 2026

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CPT procedure code and description <sup>5</sup>	Medicare Work RVUs <sup>6</sup>	Medicare national average for physician services provided in: <sup>†,7</sup>	
		Office	Facility
<b>64628</b> Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies, lumbar or sacral <sup>a,b,c</sup>	6.97	N/A	\$365
<b>+64629</b> Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure) <sup>a,b,c</sup>	3.68	N/A	\$167

N/A: The CPT code is not valued for the office setting.

# Hospital outpatient coding and payment

Effective January 1, 2026 - December 31, 2026

CPT procedure code and description <sup>5</sup>	APC <sup>8</sup>	APC Level	Status indicator <sup>8,d</sup>	Relative weight <sup>8</sup>	Medicare national average <sup>8</sup>
<b>64628</b> Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies, lumbar or sacral <sup>a,b,c</sup>	5115	Level 5	J1	143.4859	\$13,117
<b>+64629</b> Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure) <sup>a,b,c</sup>	-	-	-	-	-

# ASC coding and payment

January 1, 2026 - December 31, 2026

CPT procedure code and description <sup>5</sup>	Payment indicator <sup>9,e</sup>	Multiple procedure discounting <sup>f</sup>	Relative weight <sup>9</sup>	Medicare national average <sup>9</sup>
<b>64628</b> Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies, lumbar or sacral <sup>a,b,c</sup>	J8	Y	175.6211	\$9,891
<b>+64629</b> Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure) <sup>g</sup>	N1	-	-	-

† Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

## Annual references

1. Palmetto Billing and Coding: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (A59205). Cms.gov. Published March 5, 2023. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=59205&ver=3&keyword=basivertebral&keywordType=starts&areald=all&docType=6&contractOption=all&ortBy=relevance&bc=1>
2. Noridian Billing and Coding: Intraosseous Basivertebral Nerve Ablation (A59466). Cms.gov. Published March 5, 2026. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=59466&ver=7&keyword=basivertebral&keywordType=starts&areald=all&docType=6,P&contractOption=all&sortBy=relevance&bc=1>
3. NGS Proposed Billing and Coding: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (DA60324). Cms.gov. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=60323&ver=3>
4. HCPCS 2025 Level II Professional Edition. American Medical Association; 2024.
5. CPT Copyright © 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.
6. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. <https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip>. Although the total RVU consists of three components, only the physician work RVU is shown.
7. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1832-f>. Local physician rates will vary based on location specific factors not reflected in this document.
8. OPFS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice/cms-1834-fc>. Rates shown reflect the unadjusted OPFS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
9. ASC 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-notice/cms-1834-fc>. Rates shown reflect the unadjusted ASC payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.

## Coding footnotes

- a. Medically Unlikely Edits (MUE) allow 1 unit for 64628 and 2 units for 64629. NCCI Policy Manual 1/1/2025, Chapter I. Centers for Medicare and Medicaid Services. <https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits-mues>. Released 2/28/2025. Accessed November 4, 2025.
- b. According to CPT manual instructions, codes 64628 and 64629 are reported per vertebral body. Code 64628 is for two consecutive vertebral bodies, ie, a motion segment, and code +64629 is for each additional vertebral body. The procedure targets the main trunk of the single basivertebral nerve per vertebral level. CPT Assistant, Destruction of Intraosseous Basivertebral Nerve, March 2022, Volume 32, Issue 03, page 10. In the uncommon event only one endplate exhibits Modic Changes, and only one vertebral body was ablated, physicians may report this with 64628 plus CPT Modifier -52 (Reduced Services). To ensure payment still covers the services delivered, clearly document in this scenario the device charges and what was reduced (equipment costs vs. physician time).
- c. The definition of codes 64628 and 64629 includes image guidance. According to CPT manual instructions (parenthetical note), fluoroscopic needle guidance and localization (77003) and CT needle guidance (77012) may not be coded separately.
- d. Status Indicator (SI) shows how a code is handled for payment purposes. J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment.
- e. The Payment Indicator (PI) shows how a code is handled for payment purposes: J8 = Device-Intensive Procedure; paid at adjusted rate. N1 = Packaged service/item; no separate payment made.
- f. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y".
- g. The ASC Addenda do not include +64629 for additional levels on the ASC Covered Procedures list. This appears to be an oversight by CMS and Medtronic is working with CMS in the Annual Rulemaking cycle to evaluate addition in future years.
- h. If two non-consecutive vertebral levels are ablated in the same session no explicit coding guidance exists. It is advisable to clearly document in clinical notes what vertebral bodies were treated, what levels and endplates had Modic Changes observed, and explanation of why non-consecutive levels were treated.

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