MEDICAL POLICY	Wireless Capsule Endoscopy (Medicare Only)
Effective Date: 8/1/2022  8/1/2022 Medical Officer Date	Medical Policy Number: 308 Medical Policy Committee Approved Date: 4/2021; 5/2021; 6/2021; 11/2021; 6/2022

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Colon Capsule Endoscopy (CCE) (CPT 91113)	Local Coverage Determination (LCD): Colon Capsule Endoscopy (CCE) (L38826)
Small Bowel Wireless Endoscopy and Esophageal Capsule Endoscopy (CPT 91110, 91111)	Company medical policy for Wireless Capsule Endoscopy (All Lines of Business Except Medicare) I. These services may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. These services are considered **not medically necessary** for Medicare Plan members either when the Company medical policy criteria are **not** met ***or*** when a service is deemed "investigational" by the Company policy. *Services deemed "investigational" are considered not medically necessary for Medicare Plan members.* See *Policy Guidelines below.*
All other capsule endoscopy procedures or systems	Company medical policy for Wireless Capsule Endoscopy (All Lines of Business Except Medicare)

Examples: • *Patency capsule systems (CPT 91299)* • *Magnetically-controlled capsule endoscopy (CPT 0651T)*	I.	These services are considered not medically necessary for Medicare based on the Company medical policy. *Services deemed "investigational" are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.*

POLICY GUIDELINES

Medicare and Medical Necessity

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

BILLING GUIDLEINES

General

See associated local coverage articles (LCAs) for additional coding and billing guidance:

- LCA: Billing and Coding: Colon Capsule Endoscopy (CCE) (A58438)

Patency Capsule

To report patency capsule testing, use CPT code 91299.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report
No Prior Authorization Required	
~~0355T~~	TERMED 12/31/2021 ~~Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report~~
Not Covered	
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
91299	Unlisted diagnostic gastroenterology procedure

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.