BlueCross BlueShield of Vermont

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Wireless Capsule Endoscopy for Gastrointestinal (GI) Disorders Corporate Medical Policy

File Name: Wireless Capsule Endoscopy for Gastrointestinal (GI) Disorders
File Code: 6.01.VT33
Origination: 10/2004
Last Review: 01/2025
Next Review: 01/2026
Effective Date: 04/01/2025

Description/Summary

The wireless capsule endoscopy uses a noninvasive device to visualize segments of the gastrointestinal tract. Patients swallow a capsule that records images of the intestinal mucosa as it passes through the gastrointestinal (GI) tract. The capsule is collected after excreted and images interpreted.

Patients with Suspected GI Disorders

For individuals who have suspected small bowel bleeding (previously referred to as obscure GI bleeding) who receive wireless capsule endoscopy (CE), the evidence has demonstrated that CE can identify a bleeding source in a substantial number of patients who cannot be diagnosed by other methods, with a low incidence of adverse events. Because there are few other options for diagnosing obscure small bowel bleeding in patients with negative upper and lower endoscopy, this technique will likely improve health outcomes by directing specific treatment when a bleeding source is identified. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have suspected small bowel Crohn disease (CD) who receive wireless the evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have suspected celiac disease who receive wireless CE, the diagnostic characteristics of CE are inadequate enough to substitute for other modalities or to triage patients to other modalities. For other conditions (eg, determining the extent of CD), direct evidence of improved outcomes or a strong indirect chain of evidence to improved

outcomes is lacking. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have unexplained chronic abdominal pain who receive wireless CE, the diagnostic characteristics of CE are inadequate to substitute for other modalities or to triage patients to other modalities. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Patients with Confirmed GI Disorders

For individuals who have an established diagnosis of CD who receive wireless CE, the evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have ulcerative colitis who receive wireless CE, direct evidence of improved outcomes or a strong chain of evidence to improved outcomes is lacking. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have esophageal disorders who receive wireless CE, the evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have hereditary polyposis syndromes who receive wireless CE, evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have portal hypertensive enteropathy who receive wireless CE, the evidence is insufficient to determine the effects of the technology on health outcomes.

Acute Upper GI Bleeding

For individuals who have acute upper GI tract bleeding who receive wireless CE, the evidence is insufficient to determine the effects of the technology on health outcomes.

Colon Cancer Screening

For individuals who are screened for colon cancer who receive wireless CE, the evidence is insufficient to determine the effects of the technology on health outcomes.

Lower GI Tract Bleeding and Major Risks for Colonoscopy or Moderate Sedation

For individuals who are screened for colon polyps with evidence of lower GI tract bleeding and major risks for colonoscopy or moderate sedation who receive wireless CE, the evidence includes diagnostic accuracy studies. Relevant outcomes are overall survival, disease-specific survival, resource utilization, test validity, and other test performance measures. Studies of CE in the intended use population are necessary to determine the diagnostic characteristics of the test in the triage setting. Studies of

diagnostic characteristics alone are insufficient evidence to determine the clinical utility of CE in this population, and no studies adequately assess the impact of findings on specific health outcomes or patient adherence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Incomplete Colonoscopy

For individuals who are screened for colon polyps following an incomplete colonoscopy with adequate preparation who receive wireless CE, the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, resource utilization, test validity, and other test performance measures. Studies of CE compared to standard management with repeat colonoscopy in the intended use population are necessary to determine the diagnostic characteristics of the test in the triage setting. Studies of diagnostic characteristics alone are insufficient evidence to determine the clinical utility of CE in this population, and no studies adequately assess the impact of findings on specific health outcomes or patient adherence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Patency Capsule for Patients with Bowel Stricture

For individuals who are scheduled to undergo CE for known or suspected small bowel stricture who receive a patency capsule, the evidence includes case series. The evidence is insufficient to determine the effects of the technology on health outcomes

Magnetic Capsule Endoscopy for Patients with Suspected Gastrointestinal Disorders

For individuals who have unexplained upper abdominal complaints who receive magnetic CE, the evidence includes diagnostic accuracy studies. The diagnostic characteristics of magnetic CE are inadequate to substitute for other modalities or to triage patients to other modalities based on the current literature. Direct evidence of improved outcomes or a strong chain of evidence to improved outcomes is lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- CPT® Coding Table & Instructions

When a service may be considered medically necessary

Wireless capsule endoscopy of the small bowel may be considered **medically necessary** for the following indications:

- Suspected small bowel bleeding, as evidenced by prior inconclusive upper and lower gastrointestinal (GI) endoscopic studies performed during the current

episode of illness
- Initial diagnosis in patients with suspected Crohn disease without evidence of disease on conventional diagnostic tests such as small bowel follow-through and upper and lower endoscopy
- In patients with an established diagnosis of Crohn disease, when there are unexpected change(s) in the course of disease or response to treatment, suggesting the initial diagnosis may be incorrect and reexamination may be indicated
- For surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome

When a service is considered investigational

Other indications of wireless capsule endoscopy are considered **investigational**, including but not limited to:

- Evaluation of the extent of involvement of known Crohn disease or ulcerative colitis
- Evaluation of the esophagus, in patients with gastroesophageal reflux (GERD) or other esophageal pathologies
- Evaluation of other gastrointestinal diseases and conditions not presenting with GI bleeding, including but not limited to, celiac sprue, irritable bowel syndrome, Lynch syndrome (risk for hereditary nonpolyposis colorectal cancer), portal hypertensive enteropathy, small bowel neoplasm and unexplained chronic abdominal pain
- Evaluation of the colon, including but not limited to, detection of colonic polyps or colon cancer
- Initial evaluation of patients with acute upper GI bleeding
- Evaluation of patients with evidence of lower GI bleeding and major risks for colonoscopy or moderate sedation
- Evaluation of patients following incomplete colonoscopy

The patency capsule is considered **investigational**, including use to evaluate patency of the GI tract before wireless capsule endoscopy

Magnetic capsule endoscopy is considered **investigational** for the evaluation of patients with unexplained upper abdominal complaints and all other indications.

Reference Resources

1. Blue Cross and Blue Shield Association Policy MPRM 6.01.33 – Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon. Last Reviewed January 2024. Accessed February 2024.
2. UpToDate: Wireless video capsule endoscopy. Literature Review current through January 2023. Accessed January 2023.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm
benefits, please contact the customer service department at the member's health plan.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required.
NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

10/2004	New policy
11/2005	Updated with attachment
10/2006	Updated to add medical necessity for surveillance of the small bowel with hereditary gastrointestinal polyposis syndromes, and to delineate FDA contraindications
10/2007	Revised to mirror BCBSA Policy including format. This involved no substantive changes. Reviewed by the CAC 01/2008
05/2009	Unchanged; reviewed by CAC 05/2009
04/2010	Patency capsule added to the list of specific criteria for investigational; reviewed by CAC 05/2010
11/2011	Transferred to new policy format. References updated. Product names added. Coding table updated with ICD-9 and ICD-10 codes
03/2014	ICD-10 remediation and CPT update. CPT update from 2013 adaptive maintenance.
11/2015	Adoption of Blue Cross and Blue Shield Association MPRM# 6.01.33. Code table updated.
12/2017	Policy updated with literature review and references. Policy statements remain unchanged.
11/2018	Updated to reflect the BCBSA MPRM 6.01.33 updated November 2018. Policy statements remain unchanged.
01/2020	Updated to reflect the BCBSA MPRM 6.01.33 updated December 2019. Policy statements remain unchanged.
02/2021	Policy reviewed. References reviewed. Updated to reflect BCBSA MPRM 6.01.33: Added lower GI bleeding and major risks for colonoscopy or moderate sedation and incomplete colonoscopy to investigational policy statement.
07/2021	Adaptive Maintenance: Effective 07/01/2021 Added code 0651T as requiring prior approval.
12/2021	Adaptive Maintenance: Effective 07/01/2021 Added code 91113 as requiring prior approval.

02/2022	Policy Reviewed. Name changed FROM “Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon” TO “Wireless Capsule Endoscopy for (GI) Disorders”. Addition of use of Magnetic Capsule Endoscopy as Investigational. References updated. Changed code 0651T from Requiring prior approval to investigational.
02/2023	Policy Reviewed. Updated references. No changes to policy statements.
02/2024	Policy Reviewed. No changes made to the Policy Statement. Coding table updated removed deleted code 0355T.
01/2025	Removed codes 91110, 91112, 91113 as requiring prior approval.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors

Tom Weigel, MD, MBA
Vice President & Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I

CPT® Code List & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report.	No Prior Approval Required
CPT®	91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report.	No Prior Approval Required
CPT®	91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	No Prior Approval Required
The following code will be denied as Investigational			
CPT®	0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	Investigational
CPT®	91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report.	Investigational