Clinical Policy: Wireless Capsule Endoscopy

Reference Number: WNC.CP.261
Last Review Date: 05/24

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy describes the medical necessity criteria for Wireless Capsule Endoscopy.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover wireless capsule endoscopy when is determined to be medically necessary and the criteria are met for clinical scenarios under **ANY** item A, B, C, D, E, **OR** F below:

A. For undiagnosed obscure gastrointestinal bleeding, **ALL** of the following criteria must be met:
1. GI bleeding is significant as demonstrated by **one** of the following:
   a. an acute drop in hemoglobin/hematocrit;
   b. unexplained recurrent or persistent iron deficiency anemia demonstrated by low serum iron studies or low serum ferritin level;
   c. persistently positive fecal occult blood test; **OR**
   d. visible bleeding with no bleeding source found at original endoscopy;
2. Failure of previous diagnostic studies to diagnose the source of GI bleeding, including upper and lower GI endoscopy within the past 12 months, esophagogastroduodenoscopy (EGD) or colonoscopy; **AND**
3. Source of GI bleeding is thought to be in the upper gastrointestinal tract.

B. For suspected esophageal varices

C. For suspected Barrett's esophagus

D. For suspected Crohn's Disease when the diagnosis has not been established by upper and lower endoscopy studies, **ALL** of the following must be met:
1. Persistent abdominal pain of greater than 4 weeks;
2. Persistent diarrhea with one or more signs of inflammation (fever, elevated white blood cell count, elevated erythrocyte sedimentation rate, or bleeding)
3. Unintentional weight loss;
4. Negative stool cultures; **AND**
5. Negative upper and lower endoscopy studies.

E. For suspected Celiac disease with a positive serology and negative biopsy, **or**

F. For surveillance of the small intestine of members with hereditary polyposis syndromes.

II. WellCare of North Carolina® does **not** cover wireless capsule endoscopy in the following situations:

- **A.** Wireless capsule endoscopy for undiagnosed obscure GI bleeding or for diagnosis of suspected Crohn's disease is considered to be not medically necessary when **all** the criteria in **Subsection I.A.** (GI bleeding) or **Subsection I.D.** (Crohn's disease) are not met.
- **B.** Wireless capsule endoscopy for any indication other than undiagnosed obscure GI bleeding, diagnosis of suspected esophageal varices, suspected diagnosis of Barrett's esophagus, diagnosis of suspected Crohn's disease, diagnosis of suspected Celiac disease, or for surveillance of the small intestine of members with hereditary polyposis syndromes is considered to be experimental / investigational including the following:
  1. When the test is performed for screening.
  2. When used as an initial test in diagnosing gastrointestinal bleeding.
  3. When used as an initial test in evaluating abdominal pain.
  4. When used for evaluation of the esophagus for diseases other than esophageal varices and Barrett's esophagus.
  5. When used for the evaluation of the extent of involvement of known Crohn's disease.
  6. When used for the evaluation of the extent of involvement of known Celiac disease.
  7. When used for the evaluation of other gastrointestinal diseases including irritable bowel syndrome, small bowel neoplasm, recurrent intussusception, and duodenal lymphocytosis.
  8. When used for the evaluation of the colon for diseases, including the detection of colorectal polyps or cancer.
  9. When used in confirming pathology identified by other diagnostic means.
- **C.** Wireless capsule endoscopy for persons with known or suspected gastrointestinal obstruction, strictures, or fistulae.
- **D.** Wireless capsule endoscopy for follow-up for persons with known small bowel diseases.
- **E.** Patency capsule system used to evaluate patency of the GI tract prior to wireless capsule endoscopy or for any other indication.

Background[1]

Wireless capsule endoscopy allows for direct visualization and intervention in the gastrointestinal (GI) tract. Imaging of the GI tract is essential in the diagnosis of GI diseases. Wireless capsule endoscopy is performed using an endoscopy video camera to take thousands of pictures of the esophagus, stomach and small intestine. The endoscopy video camera sits inside a vitamin-sized capsule that is swallowed. The capsule moves passively down the digestive tract, does not inflate the bowel, and images the mucosa in the collapsed state. The endoscopy video camera uses wireless radio transmission to send the images from inside the GI tract to a receiving recorder device that the member wears around the waist. The receiving device also contains some localizing antennae sensors that can roughly gauge where the images were taken in the GI tract. The images are downloaded onto a workstation for interpretation by qualified providers.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	07/21	08/21
Reviewed CPT code.	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage.	05/23	05/23
Annual Review. Removed HCPCS & ICD-10 codes tables.	05/24	05/24

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1A-31 Wireless Capsule Endoscopy. Program Specific Clinical Coverage Policies NC Medicaid (ncdhhs.gov). Published August 15, 2023. Accessed February 5, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:
a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:
a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.