



**Capsule Endoscopy Guidelines**  
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Guideline

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# Capsule Endoscopy Guidelines

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## Guideline

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# General Guidelines (CAPEND-0)

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- The Gastrointestinal Endoscopy Program applies an evidence-based approach to evaluate the most appropriate care for each individual. This evaluation requires submission of medical records pertinent to the treatment and/or services being requested by the provider.
- If the medical records provided do not provide sufficiently detailed information to understand the individual's current clinical status, then the medical necessity for the request cannot be established and the request cannot be approved.
- A pertinent clinical evaluation since the new onset or change in symptoms is required prior to considering gastrointestinal endoscopy services:
  - A pertinent clinical evaluation should include the following:
    - A detailed history and physical examination
    - Appropriate laboratory studies
    - Pertinent imaging studies
    - Pathology reports
    - Procedure reports
    - Reports from other providers participating in the treatment of the relevant condition
  - For an established individual, a meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) since the onset or change in symptoms can serve as a pertinent clinical evaluation
- A recent clinical evaluation may be deferred if the individual is undergoing a guideline-supported, scheduled follow-up imaging or other designated procedural evaluation. Exceptions due to routine surveillance indications are addressed in the applicable condition-specific guideline sections.
- The Gastrointestinal Endoscopy Program reserves the right to change and update the policy as new evidence emerges. The policy undergoes a formal review at least annually. The policy is based upon major national and international association and society guidelines and criteria, peer reviewed literature, major treatises, as well as input from health plans, practicing academic and community-based physicians.
- This policy is not intended to supersede or replace sound medical judgment, but instead, should facilitate the identification of the most appropriate treatment given the individual's clinical condition. This policy is written to cover most gastrointestinal endoscopic indications. However, the policy may not be applicable in certain clinical circumstances. Physician judgment may override the policy. Clinical decisions, including treatment decisions, are the responsibility of the individual and his/her

- provider. Clinicians are expected to use independent medical judgment, which takes into account the clinical circumstances to determine individual management decisions
- All time intervals in this guideline refer to capsule endoscopy, unless otherwise stated.
  - Requests for Open-Access Endoscopy must meet criteria according to these guidelines.
  - New and Emerging Technologies
    - Requests related to new and emerging technologies will be considered to determine whether they meet evidence-based guidelines.
      - If a specific CPT code does not exist for a new technology, the CPT code submitted with the request will be considered based on its typical procedure application.
    - Procedures are not supported that are inconsistent with established clinical standards or are requested solely for data collection and not used in direct clinical management.
  - Capsule endoscopy is not a term applicable to every study that utilizes an ingested capsule device. There are specific types of capsules, some of which have their own independent CPT<sup>®</sup> code (e.g. wireless motility capsule (CPT<sup>®</sup> 91112), colon capsule (CPT<sup>®</sup> 91113), etc.). The specific CPT<sup>®</sup> should be used for the corresponding capsule request.
  - State and federal legislations may need to be considered in the review of gastrointestinal endoscopy requests.
  - CPT<sup>®</sup> (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT<sup>®</sup> five digit codes, nomenclature, and other data are copyright 2024 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in the CPT<sup>®</sup> book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.

### Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

# Crohn's Disease (CAPEND-1)

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- Capsule endoscopy (CE) is medically necessary for the evaluation of known or suspected Crohn's disease in the following clinical scenarios:
  - Clinical features consistent with Crohn's disease:
    - Chronic diarrhea, chronic abdominal pain, unintentional weight loss, fatigue, or evidence of gastrointestinal (GI) bleeding AND one of the following:
      - Elevated biomarkers [ESR, CRP, fecal calprotectin, or lactoferrin] OR
      - Ileocolonoscopy or advanced imaging studies are suspicious for Crohn's disease
  - To assess for the possibility of small bowel involvement in the presence of an indeterminate colitis OR
  - Known Crohn's disease and ANY of the following:
    - Clinical features unexplained by ileocolonoscopy or advanced imaging studies.
    - When assessment of small bowel mucosal healing beyond the reach of ileocolonoscopy is needed.
    - Suspected small bowel recurrence after colectomy, with negative or inconclusive ileocolonoscopy or advanced imaging studies.

## Background and Supporting Information

- Crohn's Disease
  - In a study, in individuals with both abdominal pain and diarrhea with positive inflammatory markers, the diagnostic yield of CE was 90.1% vs. 0% in those with negative inflammatory markers.
- The consensus group of the Canadian Association of Gastroenterology concluded "Capsule Endoscopy (CE) is not warranted in most individuals who present with chronic abdominal pain in the absence of positive tests for inflammatory markers or abnormal findings on endoscopy or imaging".

## Evidence Discussion

Capsule endoscopy is a useful adjunct in the diagnosis of individuals with small bowel Crohn's disease in whom there is a high index of suspicion of disease. Capsule endoscopy and small bowel imaging techniques lack the means to provide tissue when that is needed for diagnosis during evaluation of the small bowel, hence should be reserved for symptomatic individuals with abnormal inflammatory markers, who already have undergone ileocolonoscopy and advanced imaging. It can be utilized to evaluate disease activity and response to therapy with a great impact on individual management, in individuals with known Crohn's Disease. Current evidence suggests that capsule

endoscopy has limited diagnostic value in individuals presenting with chronic abdominal pain or diarrhea as their sole symptom when there is no accompanying evidence of inflammation or structural abnormality on biomarkers or imaging, including ileocolonoscopy or other advanced imaging modalities. In this population, routine use of capsule endoscopy is generally not supported.<sup>35,44,47,61,62</sup>

# Celiac Disease (CAPEND-2)

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- Capsule endoscopy (CE) is medically necessary for the evaluation of **suspected celiac disease** in the following clinical scenarios:
  - Individuals with positive celiac serology and negative small bowel biopsy
  - Individuals with chronic diarrhea or suspected malabsorption and a contraindication to biopsy or esophagogastroduodenoscopy (EGD)
  - Individuals with positive celiac serology and a contraindication to biopsy or EGD
- Capsule endoscopy (CE) is medically necessary for the evaluation of **confirmed celiac disease** in the following clinical scenario:
  - New or continued symptoms (e.g., bloating, diarrhea, abdominal pain, unintentional weight loss, distension, evidence of malabsorption, anemia) despite adherence to 6 months of a gluten-free diet

## Background and Supporting Information

- Celiac Disease
  - Celiac disease is an autoimmune disease in which the villi of the small intestine are damaged from eating gluten (found in wheat, barley, and rye).
  - Complications of celiac disease include ulcerative jejunitis, lymphoma, and small intestinal adenocarcinoma.
  - Screening blood tests include:
    - Anti-tissue transglutaminase antibody (anti-tTG), anti-endomysial antibody (anti-EMA), total IgA count to assess for IgA deficiency, CBC to detect anemia, ESR, C-reactive protein, complete metabolic panel, vitamin D, E, B12 levels.

## Evidence Discussion

Celiac disease is a disorder primarily involving the small bowel mucosa resulting in progressive degrees of villous inflammation and destruction, which begins in the duodenum and can progress over time to the ileum. Diagnosis is confirmed by serologic studies with antibody testing and upper endoscopy and small bowel biopsies. Complications of celiac disease include ulcerative jejunoileitis, small bowel lymphoma, and tumors of the small bowel. A study in the World Journal of Gastroenterology reviewed guidelines from seven scientific societies and Wireless Capsule Endoscopy (WCE), also referred to as Video Capsule Endoscopy (VCE), can support the diagnosis of celiac disease in discordant cases between serology and upper endoscopy and small bowel biopsy, in those unable to have an endoscopic procedure due to a contraindication, or if unwilling to undergo upper endoscopy and biopsy. Wireless

Capsule Endoscopy (WCE) may be medically necessary for the evaluation of individuals with celiac disease with a positive serology and negative biopsy, and for the re-evaluation of individuals with celiac disease who remain symptomatic despite treatment and there is no suspected or confirmed GI obstruction, stricture, fistulae. Individuals with confirmed celiac disease with anemia, GI bleeding, evidence of malabsorption, or in those with new or intractable symptoms despite an adequate trial of gluten restriction, may be at higher risk for complications related to celiac disease. Wireless Capsule Endoscopy (WCE) as a noninvasive study to visualize the small bowel has shown diagnostic utility in that population.<sup>4,36,38-43</sup>

# Gastrointestinal Bleeding (CAPEND-3)

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- Capsule endoscopy (CE) is medically necessary for the evaluation of gastrointestinal (GI) bleeding in the following clinical scenarios:
  - Documented overt GI bleeding (observed blood per rectum, melena, or black tarry stool excluding hematemesis) and negative findings on EGD and colonoscopy performed within the last 12 months OR
  - Repeated obscure bleeding and prior negative capsule endoscopy OR
  - Suspected obscure bleeding or UNEXPLAINED iron deficiency anemia, with negative EGD and colonoscopy performed within the last 12 months

## Evidence Discussion

Capsule endoscopy is a non-invasive and generally safe procedure that permits evaluation of portions of the GI tract that may not be accessible with traditional gastrointestinal endoscopy. It requires no pre-evaluation bowel preparation, although some clinicians choose to administer laxatives prior to the procedure. Despite prior use of upper endoscopy, small bowel enteroscopy, and/or colonoscopy, the source of gastrointestinal bleeding may remain unexplained. Capsule endoscopy has been shown to detect small intestinal bleeding sources in up to 63% of cases where traditional endoscopy was unrevealing. Evidence supports the use of capsule endoscopy in several clinical situations, particularly when other diagnostic approaches have been inconclusive. Studies have demonstrated its usefulness in evaluating the following: obscure gastrointestinal bleeding after negative EGD and colonoscopy, suspected obscure bleeding or unexplained iron deficiency anemia, or for individuals with recurrent obscure bleeding and a prior negative capsule endoscopy.<sup>55,56</sup>

# Small Bowel Tumors (CAPEND-4)

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- Capsule endoscopy is medically necessary for the evaluation of known or suspected small bowel tumors (including genetic polyposis syndromes).

## Evidence Discussion

The American Gastrointestinal Association (AGA) published guidance on the use of capsule endoscopy for individuals with polyposis syndromes who require small bowel evaluation. Evidence shows that capsule endoscopy can detect small bowel polyps, including duodenal and jejunal-ileal lesions, with a higher sensitivity than traditional endoscopy and comparable performance to other imaging modalities such as MRI enterography. In addition to familial adenomatous polyposis (FAP) and Peutz-Jeghers (PJS), capsule endoscopy has also been studied in other hamartomatous polyposis syndromes including protein tyrosine phosphatase (PTEN) associated disorders, familial juvenile polyposis, and Cronkite-Canada syndrome. The AGA stressed the value of using capsule endoscopy for surveillance especially in individuals with PJS who are at the highest risk for bleeding and intussusception related to small bowel polyps.<sup>4,33,54,58</sup>

# Genetic Syndromes (CAPEND-5)

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- Capsule endoscopy is medically necessary for the evaluation and surveillance of individuals with Juvenile Polyposis Syndrome.
  - Capsule endoscopy is medically necessary periodically.
    - The optimal periodic interval for surveillance has not been established.
- Capsule endoscopy is medically necessary for the evaluation and surveillance of individuals with Peutz-Jeghers Syndrome.
  - Capsule endoscopy is medically necessary beginning at age 8 years
    - If no polyps are identified at the initial evaluation, repeat imaging is medically necessary at age 18 years and every 2 years thereafter.
    - If polyps are detected, more frequent surveillance and therapeutic intervention (e.g., endoscopic polypectomy) should be considered due to the risk of malignant transformation.
    - In the presence of new or worsening symptoms, interval imaging sooner than every 2 years is medically necessary to assess for polyp burden or complications requiring intervention.
- Capsule endoscopy is medically necessary for the evaluation of Biallelic Mismatch Repair Deficiency (BMMRD)
  - Capsule endoscopy is medically necessary annually, beginning at age 8 years.
- Capsule endoscopy is medically necessary for the evaluation of Familial Adenomatous Polyposis (FAP), Attenuated Familial Adenomatous Polyposis (AFAP) Syndromes, and MUTYH-Associated Polyposis in the following clinical scenarios:
  - For individuals found to have Spigelman Stages III and IV (see: **EGD-1.16: Genetic Syndromes** for table of Spigelman Stages), or before duodenectomy if this is being contemplated.
    - Repeat every 2 years

## Evidence Discussion

Evidence supports the use of capsule endoscopy for the evaluation of Familial Adenomatous Polyposis (FAP), Attenuated Familial Adenomatous Polyposis (AFAP) Syndromes, and MUTYH-Associated Polyposis in the following clinical scenarios: in individuals found to have Spigelman Stages III and IV or prior to a contemplated duodenectomy, with repeat evaluation recommended every two years.<sup>4</sup>

Capsule endoscopy represents a pivotal tool in the management of FAP, particularly for evaluating the small bowel in high-risk individuals. The recommendations from leading guidelines, including the NCCN and AGA, support its use as part of a tailored surveillance strategy. By facilitating early detection and aiding in surgical planning, CE contributes to reducing morbidity and improving outcomes in FAP patients. Continued research and refinement of clinical protocols will further clarify its role in routine care.<sup>4,34</sup>

Capsule endoscopy has been shown to provide value in the evaluation of individuals with Peutz-Jeghers Syndrome (defined as individuals with perioral or buccal pigmentation and/or 2 or more histologically characteristic hamartomatous polyps, or family history of PJS, or STK11 mutations) in the following clinical scenario: Capsule endoscopy at age 8 years. If no polyps, repeat at age 18 years then every 2 years, or earlier if any symptoms occur.<sup>4,34</sup>

Capsule endoscopy plays a pivotal role in the surveillance and management of Peutz-Jeghers Syndrome. By enabling the early detection of small bowel polyps and malignancies, CE enhances the ability to mitigate cancer risks and improve outcomes in this high-risk population. The integration of CE into routine care is strongly supported by major guidelines, including the NCCN, AGA, and ACG, and represents a critical component of personalized surveillance strategies for PJS patients. Continued advancements in capsule endoscopy technology are expected to further refine its role in hereditary cancer syndromes.<sup>4,34</sup>

Evidence supports the use of Capsule endoscopy for the evaluation of BMMRD (Biallelic Mismatch Repair Deficiency) in the following clinical scenario: capsule endoscopy annually, beginning at age 8 years.<sup>10</sup>

Capsule endoscopy plays a crucial role in the surveillance of BMMRD, providing a sensitive, non-invasive method for detecting small bowel neoplasms. Supported by guidelines from the NCCN, AGA, and US Multi-Society Task Force, CE is an essential component of comprehensive surveillance strategies for this high-risk population. By enabling early detection and guiding timely interventions, capsule endoscopy significantly contributes to improving outcomes and quality of life for individuals with BMMRD. Further research and advancements in CE technology will continue to refine its application in hereditary cancer syndromes.<sup>10</sup>

Capsule endoscopy is supported for the evaluation of Juvenile Polyposis Syndrome (defined as individuals with 5 or more juvenile polyps in the colorectum or any juvenile polyps in other parts of the GI tract, or evidence of SMAD4 or BMPRI1A mutations). There is currently no universally established age or start time for initiating capsule endoscopy in individuals with Juvenile Polyposis Syndrome (JPS). While capsule endoscopy is increasingly a recognizable tool for small bowel surveillance, guidelines provide general recommendations without defining a strict timeline. The Multi-Society Task Force suggest that small bowel evaluation, including CE may be medically necessary in childhood, typically between 8 and 10 years of age, if symptomatic or

polyps are identified through other imaging modalities. Despite this recommendation, the literature emphasizes that the optimal initiation time for CE has not been formally established, and surveillance should be individualized based on clinical presentation, polyp burden, and genetic findings.<sup>33</sup>

Capsule endoscopy represents a promising tool for small bowel surveillance in Juvenile Polyposis Syndrome, complementing traditional endoscopic techniques. While current guidelines do not mandate CE use, its ability to detect small bowel polyps underscores its potential to improve disease management and outcomes. Further research is needed to establish CE's role in JPS-specific surveillance protocols and optimize care for this high-risk population.<sup>4,34</sup>

# Colon Capsule Endoscopy (CAPEND-7)

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- Colon capsule endoscopy is medically necessary in the following clinical scenarios:
  - As a primary procedure in individuals with contraindications for standard optical colonoscopy or procedural sedation AND one of the following:
    - Fecal occult blood test positive OR
    - Multitarget Stool DNA (sDNA) test positive OR
    - Other evidence of lower GI bleeding in hemodynamically stable individuals
  - As a secondary procedure:
    - For the detection or surveillance of colon polyp(s) if the diagnostic optical colonoscopy was incomplete OR
    - When an incomplete diagnostic optical colonoscopy was performed for either:
      - Multitarget Stool DNA (sDNA) test positive OR
      - Other evidence of lower GI bleeding in hemodynamically stable individuals
- Colorectal Cancer Screening
  - Colon capsule endoscopy is considered not medically necessary for colorectal cancer screening.

## Evidence Discussion

The video colon capsule affords the benefit of visualizing colonic mucosa under physiologic conditions without exposing the individual to radiation or sedation.

In 2017, the Multi-Society Task Force (MSTF) representing the American College of Gastroenterology (ACG), American Gastroenterology Association (AGA), and American Society of Gastrointestinal Endoscopy (ASGE) recommended colon capsule endoscopy every 5 years as the third tier test for colon cancer screening. The European Society of Gastrointestinal Endoscopy (ESGE) also recommends colon capsule endoscopy as a screening test for colon cancer screening in average-risk individuals when optical colonoscopy is contraindicated, vehemently opposed by the individual, or technically impossible.<sup>15</sup>

Although colon capsule endoscopy (CCE) has a high level of accuracy, it is less sensitive and specific than colonoscopy in individuals undergoing colorectal cancer (CRC) screening/surveillance or those with known or suspected colonic diseases.<sup>1,3,4,15,59,60</sup>

In cases in which a previous colonoscopy was incomplete or for individuals who are unable/unwilling to undergo colonoscopy, colon capsule endoscopy (CCE) has

been shown to be a reasonable alternative and may be as good as or better than CT Colonography in detecting significant polyps.<sup>1,3,4,15,59,60</sup>

In addition to lower sensitivity and specificity than colonoscopy, colon capsule endoscopy (CCE) also is limited by an inability to insufflate the colon, aspirate liquids, control the transit of the CCE, and clean the mucosal surface. Individuals with significant polyps on CCE also theoretically will require subsequent polypectomy, thereby requiring 2 procedures and increasing resource utilization.<sup>1,3,4,15,59,60</sup>

Based on the higher polyp detection rate with colonoscopy and the added benefit of being able to perform polypectomy during the same procedure, it is recommended that CCE not be substituted routinely for colonoscopy. However, in individuals who are unwilling or unsuitable for colonoscopy, CCE is an appropriate alternative.<sup>1,3,4,15,59,60</sup>

In individuals with inflammatory bowel disease (IBD), substituting colon capsule for colonoscopy to assess the extent and severity of disease is not recommended. Colon capsule endoscopy (CCE) has been shown to underestimate the extent and severity of disease compared with colonoscopy in individuals with ulcerative colitis or Crohn's disease. Consequently, colonoscopy should remain the preferred procedure to assess active disease in individuals with colitis or small bowel disease.<sup>1,3,4,15,59,60</sup>

# Esophageal Capsule Endoscopy (CAPEND-8)

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- Esophageal capsule endoscopy is medically necessary in the following clinical scenario:
  - When endoscopic procedures may be inappropriate or contraindicated, such as:
    - Individuals with non-reversible coagulopathy OR
    - Recent MI OR
    - Evaluation of esophageal varices in cirrhotic individuals who are unable to tolerate or undergo EGD

## Evidence Discussion

Esophageal capsule endoscopy (ECE) provides the opportunity of visualizing esophageal mucosa under physiologic conditions without exposing the individual to radiation or sedation. PillCam ESO was approved by the FDA in 2004. Esophageal capsule endoscopy (ECE) may be beneficial in the evaluation of esophagitis, Barrett's esophagus, esophageal cancer, and esophageal varices for individuals who are unwilling or unable to have an endoscopy.<sup>6</sup>

Several studies have been conducted to evaluate capsule endoscopy as a less invasive and more convenient endoscopic procedure for diagnosing gastroesophageal reflux disease (GERD) and Barrett's esophagus. However, the diagnostic rates for Barrett's esophagus were not sufficiently accurate for esophageal capsule endoscopy (ECE) to replace EGD as the standard diagnostic modality. Lacking the ability to obtain histological samples or perform therapeutic procedures, both of which are required during the diagnosis and surveillance of Barrett's esophagus, is a significant limitation of esophageal capsule endoscopy (ECE).<sup>6,60</sup>

Esophageal capsule endoscopy (ECE) was investigated as a less-invasive alternative to EGD for diagnosing esophageal varices. Esophageal capsule endoscopy (ECE) could be an alternative to EGD in the evaluation of esophageal varices, for the screening of cirrhotic individuals, and for indicating primary prophylactic treatment. It can play a role in individuals with contraindications for EGD or those who refuse it. Although ECE may be beneficial for screening, unlike endoscopic treatment, including band ligation and chemical sclerotherapy, this cannot be performed with ECE.<sup>6,60</sup>

# Wireless Motility Capsule Endoscopy (CAPEND-9)

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- Wireless motility capsule is medically necessary for the evaluation of suspected gastrointestinal (GI) motility disorders after structural issues are ruled out by imaging or traditional endoscopy. Wireless motility capsule is medically necessary for:
  - Evaluation and/or treatment of individuals with suspected gastroparesis in the absence of obstruction
  - Evaluation of colonic transit in individuals with chronic idiopathic constipation lasting over 6 months
  - Evaluation of small bowel motility
- Wireless motility capsule endoscopy is NOT medically necessary for individuals with any of the following:
  - History of gastric bezoar
  - Swallowing disorders
  - Dysphagia
  - Suspected strictures or fistulae in the gastrointestinal tract
  - Physiologic gastrointestinal obstruction
  - Recent (within the last 3 months) gastrointestinal surgery
  - Crohn's disease
  - Diverticulitis
  - Implanted electromechanical medical devices (i.e., pacemaker, infusion pump)

## Background and Supporting Information

- Wireless motility capsule (WMC) testing involves a swallowed, sensor-based capsule that measures pressure, pH, temperature, and transit time as it moves through the gastrointestinal tract. It provides data on:
  - gastric emptying time
  - colonic transit time
  - whole gut transit time
  - pressure patterns from the antrum and duodenum.

## Evidence Discussion

Wireless Motility Capsule (WMC) is FDA authorized for evaluation of gastroparesis and chronic constipation.<sup>30-32</sup>

Wireless Motility Capsule (WMC) offers several advantages over scintigraphy such as the following<sup>30-32</sup>:

- detects a higher proportion of subjects with delayed gastric emptying in non-diabetics
- provides a measure of gastric contractile amplitude corresponding to the timing of capsule emptying as documented by change in pH when the capsule traverses the pylorus

# Capsule Endoscopy CPT Codes

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CPT Codes

Capsule Endoscopy

## CPT Codes

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The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

CPT Code	Code Description
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report
91111	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with physician interpretation and report
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
91113	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report

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