Benefit Coverage:

<table>
<thead>
<tr>
<th>Covered Benefit for lines of business including:</th>
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<tbody>
<tr>
<td>Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB)</td>
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<tr>
<th>Excluded from Coverage:</th>
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<tbody>
<tr>
<td>Extended Family Planning (EFP) Rhody Health Partners (RHP), Rhody Health Options (RHO) Unity, Integrity Medicare Medicaid Plan (MMP), Rhody Health Expansion (RHE), and Health Benefit Exchange (HBE)</td>
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</tbody>
</table>

Description
Capsule endoscopy, also called wireless capsule endoscopy (WCE) or video capsule endoscopy (VCE), is a non-invasive diagnostic imaging procedure used to examine the entire length of the small intestines. A small capsule is swallowed, is propelled by peristalsis, and transmits video pictures. The images are transferred to a recorder and then to a computer. The capsule passes naturally with the stool and is disposable. WCE is considered to be a valuable tool for examination of the small bowel.

Coverage Determination

<table>
<thead>
<tr>
<th>Requires Authorization</th>
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<tbody>
<tr>
<td>1. Neighborhood Health Plan of Rhode Island (Neighborhood) covers Capsule Endoscopy when medical necessity criteria are met. <strong>Prior authorization is required.</strong> Approval is based on review of the medical necessity documentation.</td>
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</table>

Criteria
Capsule endoscopy is considered a clinical option when

1. Requested by a contracted practitioner,
2. The capsule is FDA approved,
3. And any **One** of the following conditions have been met:
   - **Occult Gastrointestinal Bleeding** WCE is indicated for evaluations of ongoing occult gastrointestinal bleeding and/or anemia and/or persistent bleeding with site not identified by previous testing. This test is considered if both colonoscopy and upper endoscopy have been done within the past year. **OR**
   - **Angiodysplasia** WCE is indicated if angiodysplasia of the GI tract is suspected. Again, this test is considered if both colonoscopy and upper endoscopy have been done within the past year. **OR**
   - **Heredity Polyposis Syndromes** WCE is indicated for the evaluation and surveillance of hereditary polyposis syndromes involving the small bowel. **OR**
   - **Crohn’s Disease** WCE is indicated when the diagnosis of Crohn’s disease is suspected but has not diagnosed by previous endoscopic or radiographic procedures. (WCE may also be indicated if the diagnosis of Crohn’s disease is known but it is necessary to determine whether there is involvement of the small bowel as well.)
☐ Colitis  WCE may be indicated when a member present with a diagnosis of colitis of an indeterminate type, affecting the colon, is known and a more specific diagnosis is sought by evaluating possible small bowel involvement. OR 

☐ Small Bowel Neoplasm  WCE may be indicated for evaluation of suspected, but undiagnosed, small bowel neoplasm. OR 

- Exclusions 
WCE is not reimbursable for evaluation of the esophagus or the colon. In addition, WCE is not considered medically necessary (and is not reimbursable) in the following situations:
1.  The confirmation of lesion pathology, or the management of conditions diagnosed by prior endoscopy (including push enteroscopy), colonoscopy or radiological procedures
2.  Patients with hematemesis
3.  Evaluation of esophageal lesions (e.g., suspected gastroesophageal reflux disease, Barrett's Esophagus, or esophageal varices)
4.  Patency Capsule testing is not reimbursable. (Patency capsule testing is used to verify adequate patency of the GI tract prior to administration of the PillCam video capsule in patients with known or suspected strictures. Although use of WCE can be hazardous for patients with obstruction or stricture, the use of the patency capsule as a means to locate obstructions and /or strictures is considered experimental at this time.)
5.  This test is not reimbursable for evaluation of colonic processes or for colorectal cancer screening 
6.  This test is not reimbursable for the confirmation of lesions or pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum) 
7.  Patient convenience alone 
8.  Capsule endoscopy is contraindicated in persons with known or suspected gastrointestinal obstruction, strictures, or fistulae (see exclusion number 4)

- CMP Cross Reference:

Please access Prior Authorization forms by visiting Neighborhood’s website at www.nhpr.org
1.  Go to the section for Providers
2.  Click on “Resources & FAQ’s”
3.  Click on “Medical Management Request Forms”- forms are listed alphabetically by program.

Prior Authorization Forms
For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060. Fax authorization forms to 401-459-6023.

Covered Codes: For information on Coding please reference the Authorization Quick Reference Guide
Clinical Medical Policy
Capsule Endoscopy - # 011

Last reviewed: 07/11/2017

Created:
Annual Review Month: July
Review Dates: 7/01/10, 7/06/11, 7/10/12, 7/1/13, 7/15/14, 7/7/15, 6/20/17
Revision Dates: 6/06/07, 7/06/10, 7/16/13
CMC Review Date: 7/13/10, 7/12/11, 7/12/12, 7/16/13, 7/15/14, 7/7/15, 7/12/16, 7/11/17
Medical Director's Approval Dates: 8/01/04, 6/14/07, 7/13/10, 9/20/11, 10/02/12, 7/18/13, 8/1/14,
Effective Date: 7/12/16, 7/18/17
Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:
This medical policy is made available to you for informational purposes only. It is not a guarantee of payment
or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are
determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this
medical policy. For information on member-specific benefits, call member services. This policy is current at
the time of publication; however, medical practices, technology, and knowledge are constantly changing.
Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or
without notice.

References:


