



Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage **MUST** be verified in the member's EOC or benefit document
 - Please refer to Medicare Coverage Database requirements for wireless capsule or video endoscopy determinations for Medicare members.
 - Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines
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I. **Specialties:** Primary Care, Internal Medicine, Gastroenterology
Related Medical Coverage Policies: Virtual Colonoscopy

II. **Indications for coverage**

- A.** Diagnosis of small intestine bleeding of obscure etiology with objective evidence of bleeding with one or more of the following:
1. Positive, persistent fecal occult blood testing or
 2. Iron deficiency anemia or
 3. Blood loss visualized in the rectum **AND** gastrointestinal bleeding source has not been identified with both of the following tests:
 - a. Esophagogastroduodenoscopy (EGD); and
 - b. Colonoscopy
 4. For evaluation or reevaluation of suspected or known small bowel neoplasms.
- B.** Diagnosis of suspected Crohn's disease (regional enteritis) that meet the conditions under 1 and 2 below:
1. Two or more of the following symptoms and signs associated with Crohn's disease, such as:
 - a. abdominal pain;
 - b. diarrhea;
 - c. fever;
 - d. elevated white blood count;
 - e. elevated erythrocyte sedimentation rate;
 - f. documented weight loss;
 - g. gastrointestinal bleeding with positive fecal occult blood test or blood loss visualized in stool

And
 2. One of the following test series outcomes



- a. Upper GI with small bowel follow through does not reveal an obstruction or stricture (patients with a suspected fistula or stricture will need an UGI with small bowel follow through); or,
 - b. EGD and colonoscopy do not reveal the location of the pathology.
- C. Suspected small bowel tumors including loco-regional carcinoid tumors of the small bowel with carcinoid syndrome.
- D. Evaluation of celiac disease with a negative biopsy and positive serology or unable to undergo upper endoscopy.
- E. For small bowel surveillance in Lynch syndrome, Familial Adenomatous Polyposis, Peutz-Jegher's syndrome and other inherited polyposis syndromes.
- F. For evaluation of the esophagus after radio-frequency ablation of lesions in the esophagus
- G. For re-evaluation of Crohn's or Celiac disease which remains symptomatic despite treatment, requested, or recommended by gastroenterology for medical necessity and where there is no suspected or confirmed gastrointestinal obstruction, stricture, or fistulae.
- H. For screening or surveillance of esophageal varices in cirrhotic persons with significantly compromised liver function (i.e., Child-Pugh score of Class B or greater) or other situations where a standard upper endoscopy with sedation or anesthesia is contraindicated.

III. **Contraindications for use**

- A. Absolute contraindications
 - 1. Obstruction; and
 - 2. Pregnancy
- B. Relative contraindications
 - 1. Fistulas; and
 - 2. Intestinal strictures

IV. **Exclusions**

Capsule endoscopy is considered **experimental/investigational and excluded from coverage** for all other indications including but not limited to the following:

- 1. Screening colonoscopy;
- 2. Initial test for gastrointestinal bleeding;
- 3. Confirmation of lesions or pathology normally within the reach of upper (EGD) and lower (colonoscopy) endoscopies (lesions proximal to ligament of Treitz or distal to the ileum);
- 4. Hematemesis; and
- 5. Suspected Irritable Bowel Disease, Celiac Sprue, and malabsorption as initial testing



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 KAISER PERMANENTE [®] Mid-Atlantic States	Capsule Endoscopy Medical Coverage Policy
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Approval History

Date approved by RUMC*	Date filed with the State of Maryland	Date of Implementation (Ten days after filing)
09/25/2012	09/27/2012	10/08/2012
09/26/2013	09/26/2013	10/07/2013
10/22/2014	10/29/2014	11/10/2014
10/21/2015	10/22/2015	11/02/2015

Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill [HB 798](#) – Health Insurance – Reporting

Date approved by RUMC*	Date of Implementation
10/21/2016	10/21/2016
10/25/2017	10/25/2017
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09/27/2021	09/27/2021
08/31/2022	08/31/2022
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07/24/2024	07/24/2024

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.