

CAPSULE ENDOSCOPY

Date of origin: July 11, 2025

Review dates: None yet recorded

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Capsule endoscopy is a noninvasive, sedation-free procedure that uses a small, swallowable capsule with a built-in camera to capture images of the colon. As it moves through the digestive tract, the capsule transmits images to a recorder worn by the patient. These images are then compiled into a video for a healthcare provider to review for any abnormalities.

MEDICAL POLICY

- [Capsule Endoscopy](#) (#91476)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

POLICY SPECIFIC INFORMATION**Documentation requirements**

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

CPT codes

Code	Description
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with physician interpretation and report
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation. Incorrect application of modifiers will result in denials. Get more information on modifier use [in our Provider Manual](#).

These procedures have both a technical and professional component.

- To report the professional component, append modifier 26.
- To report technical component, append modifier TC.

To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. Visualization of the esophagus, stomach, duodenum, ileum, colon is not reported separately. Report modifier 52 if the ileum is not visualized.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. [See our fee schedules](#) (login required).

REFERENCES

- [Article - Billing and Coding: Colon Capsule Endoscopy \(CCE\) \(A58471\)](#) (CMS)
- [LCD - Colon Capsule Endoscopy \(CCE\) \(L38837\)](#) (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made