Priority Health	BILLING POLICY No. 112
CAPSULE ENDOSCOPY	
Date of origin: July 11, 2025	**Review dates: 7/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation for capsule endoscopy procedures, ensuring claims are processed according to contractual agreements and industry standards

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 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

Coding Specifics

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

CPT codes 91110 and 91113- Refer to medical policy 91476 for applicable diagnosis requirements and medical necessity criteria

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 technical and professional components.

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

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 for any applicable defined guidelines.

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
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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, HCPCPS, 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 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 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
July 20, 2026	Added- "Refer to Medical policy 91476 for applicable diagnosis requirements and medical necessity criteria"