

# Gastroesophageal and Gastrointestinal (GI) Services and Procedures

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[Instructions for Use](#)

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Related Medicare Advantage Policy Guideline
• <a href="#">Capsule Endoscopy</a>

## Coverage Guidelines

Gastroesophageal and gastrointestinal services and procedures are covered when Medicare coverage criteria are met.

**Note:** The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the [Medicare Coverage Database](#) to search for applicable coverage policies (National Coverage Determination, Local Coverage Determinations and Local Coverage Articles). (Accessed May 21, 2024)

### Wireless Capsule Endoscopy (CPT Codes 91110 and 91111)

Medicare does not have an NCD for wireless capsule endoscopy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Wireless Capsule Endoscopy](#).

**For coverage guidelines for states/territories with no LCDs/LCAs,** refer to the InterQual® CP: Procedures, Capsule Endoscopy.

[Click here to view the InterQual® criteria.](#)

**Note:** After checking the [Wireless Capsule Endoscopy](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. (Accessed May 21, 2024)

### Colon Capsule Endoscopy (CCE) (CPT Code 91113)

Medicare does not have an NCD for colon capsule endoscopy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) **exist for all states/territories** and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Colon Capsule Endoscopy](#).

## **Electrogastrography or Electroenterography (CPT Codes 91132 and 91133)**

Medicare does not have a National Coverage Determination (NCD) for electrogastrography or electroenterography. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled [Gastrointestinal Motility Disorders, Diagnosis and Treatment](#).

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed May 21, 2024)

## **Virtual Colonoscopy, also known as Computed Tomographic Colonography (CTC) (CPT Codes 74261, 74262, and 74263)**

Medicare does not have an NCD for virtual colonoscopy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Virtual Colonoscopy \(Computed Tomographic Colonography\)](#).

For non-screening CTC coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Computed Tomographic Colonography](#).

**Note:** After checking the [Virtual Colonoscopy \(Computed Tomographic Colonography\)](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed May 21, 2024)

## **Screening CTC for Colorectal Cancer**

Effective May 12, 2009, CMS has determined that the current evidence is inadequate to conclude that CTC is an appropriate colorectal cancer screening test, therefore, CTC for colorectal cancer screening remains nationally non-covered. Refer to the [NCD for Colorectal Cancer Screening Tests \(210.3\)](#). (Accessed May 21, 2024)

## **Gastric Electrical Stimulation Therapy (e.g., Enterra®) (CPT Codes 43647, 43648, 43881, 43882, 64590, and 64595)**

Medicare does not have an NCD for gastric electrical stimulation therapy (e.g., Enterra®). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled [Gastrointestinal Motility Disorders, Diagnosis and Treatment](#).

### **Notes:**

- After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
- When CPT code 64590 is used for peripheral nerve stimulation, refer to the Medicare Advantage Medical Policy titled [Electrical Stimulators](#).
- For sacral nerve stimulation for incontinence, refer to the Coverage Summary titled [Urinary and Fecal Incontinence: Diagnosis and Treatment](#).

(Accessed May 21, 2024)

## **Virtual Upper Gastrointestinal Endoscopy (CPT Codes 76497 and 76498)**

Medicare does not have an NCD for virtual upper gastrointestinal endoscopy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled [Virtual Upper Gastrointestinal Endoscopy](#).

**Note:** After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed May 21, 2024)

## Endoscopic Excision of Rectal Tumors (CPT Code 0184T)

Medicare does not have an NCD for Transanal Endoscopic Microsurgery (TEMS). Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Endoscopic Excision of Rectal Tumors](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Transanal Minimally Invasive Surgical Procedures](#).

**Note:** After checking the [Endoscopic Excision of Rectal Tumors](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed May 21, 2024)

## Supporting Information

Wireless Capsule Endoscopy Accessed May 21, 2024				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L34081 (A56461)	<a href="#">Endoscopy by Capsule</a>	Part A and B MAC	CGS Administrators, LLC	KY, OH
L33774 (A56704)	<a href="#">Wireless Capsule Endoscopy</a>	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L35089 (A57753)	<a href="#">Wireless Capsule Endoscopy</a>	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L36427 (A56727)	<a href="#">Wireless Capsule Endoscopy</a>	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
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Virtual Colonoscopy (Computed Tomographic Colonography) Accessed May 21, 2024				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L34055 (A56800)	<a href="#">Virtual Colonoscopy (CT Colonography)</a>	Part A and B MAC	CGS Administrators, LLC	KY, OH
L33562 (A57026)	<a href="#">Computed Tomographic (CT) Colonography for Diagnostic Uses</a>	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, WI, VT
L33452 (A56772)	<a href="#">Virtual Colonoscopy (CT Colonography)</a>	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
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Endoscopic Excision of Rectal Tumors Accessed May 21, 2024				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38551 (A58000)	<a href="#">Transanal Endoscopic Surgery (TES)</a>	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L35490 (A56902)	<a href="#">Category III Codes</a>	Part A and B MAC	Wisconsin Physicians Service. Corp.*	IN, IA, KS, MI, MO, NE
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## Colon Capsule Endoscopy (CCE)

Accessed May 21, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38777 (A58362)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	CGS Administrators, LLC	KY, OH
L38805 (A58410)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L38571 (A58294)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, WI, VT
L38824 (A58436)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L38826 (A58438)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA-NORTHERN, CA-SOUTHERN, GU, HI, MP, NV
L38807 (A58414)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L38755 (A58321)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L38837 (A58471)	<a href="#">Colon Capsule Endoscopy (CCE)</a>	Part A and B MAC	Wisconsin Physicians Service Insurance Corporation*	IA, IN, KS, MI, MO, NE

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### MACs with Corresponding States/Territories

MACs	States/Territories
CGS	KY, OH
First Coast	FL, PR, VI
NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
Noridian	AK, AS, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto	AL, GA, NC, SC, TN, VA, WV
WPS*	IA, IN, KS, MI, MO, NE

\*Note: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers

## Policy History/Revision Information

Date	Summary of Changes
07/01/2024	<p><b>Notice of Revision:</b> The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the additional updates to be applied on <b>Jul. 1, 2024</b>.</p> <p><b>Coverage Guidelines</b></p> <ul style="list-style-type: none"> <li>• Removed content/language addressing: <ul style="list-style-type: none"> <li>○ <b>Bariatric surgery</b></li> <li>○ Endoscopy</li> <li>○ <b>Intestinal bypass</b></li> <li>○ <b>Gastric balloon for treatment of obesity</b></li> <li>○ Endoscopic procedures for treatment of gastroesophageal reflux disease (GERD) (includes Stretta<sup>®</sup> procedure, Bard EndoCinch<sup>™</sup> Suturing System, and Plicator<sup>™</sup> and Enteryx<sup>™</sup> systems) (CPT code 43257)</li> <li>○ LINX<sup>®</sup> reflux management system for the treatment of gastroesophageal reflux disease (GERD) (CPT code 43284)</li> </ul> </li> </ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>○ <b>Fecal calprotectin testing (CPT code 83993)</b></li> <li>○ Per oral endoscopic myotomy (POEM) (CPT codes 43497 and 43499)</li> <li>○ Gastric peroral endoscopic myotomy (G-POEM) (CPT codes 43497 and 43499)</li> <li>○ Rectal sensation, tone, and compliance test (CPT code 91120)</li> <li>○ Modified barium swallow (MBS) (CPT codes 74210, 74220, 74221, and 74230)</li> </ul> <p><b>Endoscopic Excision of Rectal Tumors (CPT Code 0184T)</b></p> <ul style="list-style-type: none"> <li>• Updated language pertaining to states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs): <ul style="list-style-type: none"> <li>○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled <i>Transanal Minimally Invasive Surgical Procedures</i> for coverage guidelines</li> <li>○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i></li> </ul> </li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Updated lists of applicable LCDs/LCAs to reflect the most current information: <ul style="list-style-type: none"> <li>○ Modified reference information for <i>Endoscopic Excision of Rectal Tumors</i></li> <li>○ Removed reference information for: <ul style="list-style-type: none"> <li>▪ <i>Endoscopic Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD) (Stretta® procedure, Bard EndoCinch™ Suturing System, Plicator™ and Enteryx™ systems)</i></li> <li>▪ <i>LINX® Reflux Management System for the Treatment of GERD</i></li> <li>▪ <i>Modified Barium Swallow (MBS)</i></li> </ul> </li> </ul> </li> </ul> <p><b>Administrative</b></p> <ul style="list-style-type: none"> <li>• Archived previous policy version MCS039.11</li> </ul>

## Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines.

UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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