Policy Statement

Wireless capsule endoscopy of the small bowel may be considered medically necessary when both of the following conditions are met:

I. When the procedure is NOT intended for all of the below:
   A. To evaluate the extent of involvement of known Crohn disease or ulcerative colitis
   B. To evaluate the esophagus, in patients with gastroesophageal reflux or other esophageal pathologies
   C. To evaluate other gastrointestinal (GI) diseases and conditions not presenting with GI bleeding, including but not limited to, celiac sprue, irritable bowel syndrome, lymphatic malformation, small bowel neoplasm, screening for colonic polyps or cancer and unexplained chronic abdominal pain
   D. For Initial evaluation of patients with acute upper GI bleeding
   E. To evaluate patients with evidence of lower GI bleeding and major risks for colonoscopy or moderate sedation
   F. To evaluate patients following incomplete colonoscopy

II. If the procedure is intended for any of the below:
   A. Suspected small bowel bleeding, and both of the following:
      1. Inconclusive upper gastrointestinal (GI) endoscopy during the current episode of illness
      2. Inconclusive lower GI endoscopy (colonoscopy) during the current episode of illness
   B. Initial diagnosis in patients with suspected Crohn disease without evidence of disease on conventional diagnostic tests (such as small bowel follow-through [SBFT] and upper and lower endoscopy)
   C. Established diagnosis of Crohn disease, with unexpected change(s) in the course of disease or response to treatment, suggesting the initial diagnosis may be incorrect and reexamination may be indicated
   D. For surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome

Wireless Capsule Endoscopy is considered investigational if the patient's situation does not meet the criteria above.

The patency capsule is considered investigational, including use to evaluate patency of the GI tract before wireless capsule endoscopy.

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Suspected small bowel bleeding, previously referred to as obscure gastrointestinal (GI) tract bleeding is defined as recurrent or persistent iron-deficiency anemia: positive fecal occult blood test; or visible bleeding with no bleeding source found at original endoscopy.

Coding

The following CPT code specifically describes the use of the capsule camera:
- 91110: Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report
The following CPT code is also specific to capsule endoscopy of the esophagus alone:
- **91111**: Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report

The following is a category III CPT code for capsule endoscopy of the colon:
- **0355T**: Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report

**Description**

The wireless capsule endoscopy (CE) uses a noninvasive device to visualize segments of the gastrointestinal tract. Patients swallow a capsule that records images of the intestinal mucosa as it passes through the gastrointestinal (GI) tract. The capsule is collected after being excreted and images interpreted.

**Related Policies**

- N/A

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

Table 1 summarizes various wireless CE devices with clearance by the U.S. Food and Drug Administration.

Code used: NEZ

<table>
<thead>
<tr>
<th>Device</th>
<th>Manufacturer</th>
<th>Date Cleared</th>
<th>510(k) No.</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>CapsoCam Plus (SV-3)</td>
<td>CapsoVision Inc.</td>
<td>4/19/2019</td>
<td>K183192</td>
<td>For visualization of the small bowel mucosa in adults. It may be used as a tool in the detection of abnormalities of the small bowel.</td>
</tr>
<tr>
<td>Olympus Small Intestinal Capsule Endoscope System</td>
<td>Olympus Medical Systems Corp.</td>
<td>3/5/2019</td>
<td>K183053</td>
<td>For visualization of the small intestine mucosa.</td>
</tr>
<tr>
<td>MiroCam Capsule Endoscope System</td>
<td>IntroMedic Co. Ltd.</td>
<td>11/8/2018</td>
<td>K180732</td>
<td>May be used as a tool in the detection of abnormalities of the small bowel and this device is indicated for adults and children from 2 years of age.</td>
</tr>
<tr>
<td>Olympus Small Intestinal Capsule Endoscope System</td>
<td>Olympus Medical Systems Corp.</td>
<td>3/13/2018</td>
<td>K173459</td>
<td>May be used in the visualization and monitoring of lesions that may indicate Crohn's disease not detected</td>
</tr>
<tr>
<td>Device</td>
<td>Manufacturer</td>
<td>Date Cleared</td>
<td>510(k) No.</td>
<td>Indication</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------</td>
<td>--------------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PillCam Patency System</td>
<td>Given Imaging Ltd.</td>
<td>3/8/2018</td>
<td>K180171</td>
<td>Intended to verify adequate patency of the gastrointestinal tract prior to administration of the PillCam video capsule in patients with known or suspected strictures.</td>
</tr>
<tr>
<td>MiroCam Capsule Endoscope System</td>
<td>IntroMedic Co. Ltd.</td>
<td>1/30/2018</td>
<td>K170438</td>
<td>For visualization of the small intestine mucosa.</td>
</tr>
<tr>
<td>PillCam SBC capsule endoscopy system</td>
<td>Given Imaging Ltd.</td>
<td>9/1/2017</td>
<td>K170210</td>
<td>For visualization of the small intestine mucosa.</td>
</tr>
<tr>
<td>PillCam Desktop Software 9.0</td>
<td>Given Imaging Ltd.</td>
<td>5/26/2017</td>
<td>K170839</td>
<td>Intended for visualization of the small bowel mucosa.</td>
</tr>
<tr>
<td>RAPID Web</td>
<td>Given Imaging Ltd.</td>
<td>3/10/2017</td>
<td>K163495</td>
<td>Intended for visualization of the small bowel mucosa.</td>
</tr>
<tr>
<td>OLYMPUS SMALL INTESTINAL CAPSULE ENDOSCOPE SYSTEM</td>
<td>OLYMPUS MEDICAL SYSTEMS CORP.</td>
<td>1/19/2017</td>
<td>K163069</td>
<td>Intended for visualization of the small bowel mucosa.</td>
</tr>
<tr>
<td>CapsoCam Plus (SV-3) Capsule Endoscope System</td>
<td>CapsoVision Inc.</td>
<td>10/21/2016</td>
<td>K161773</td>
<td>Intended for visualization of the small bowel mucosa.</td>
</tr>
<tr>
<td>CapsoCam (SV-1)</td>
<td>CapsoVision Inc.</td>
<td>2/9/2016</td>
<td>K151635</td>
<td>For use in diagnosing disorders of the small bowel, esophagus, and colon.</td>
</tr>
<tr>
<td>PillCam COLON2</td>
<td>Given® Imaging</td>
<td>1/14/2016</td>
<td>K153466</td>
<td>Detection of colon polyps in patients after an incomplete colonoscopy and a complete evaluation of the colon was not technically possible, and for detection of colon polyps in patients with evidence of GI bleeding of lower GI origin with major risks for colonoscopy or moderate sedation, but who could tolerate colonoscopy or moderate sedation in the event a clinically significant colon abnormality was identified on capsule endoscopy.</td>
</tr>
<tr>
<td>ENDOCAPSULE SOFTWARE 10; ENDOCAPSULE SOFTWARE 10 LIGHT</td>
<td>OLYMPUS MEDICAL SYSTEMS CORP.</td>
<td>2/8/2015</td>
<td>K142680</td>
<td>Intended for visualization of the small bowel mucosa.</td>
</tr>
</tbody>
</table>

GI: gastrointestinal.
Rationale

Background

Wireless Capsule Endoscopy

Wireless CE is performed using the PillCam Given Diagnostic Imaging System (previously called M2A), which is a disposable imaging capsule manufactured by Given Imaging. The capsule measures 11 by 30 mm and contains video imaging, self-illumination, and image transmission modules, as well as a battery supply that lasts up to 8 hours. The indwelling camera takes images at a rate of 2 frames per second as peristalsis carries the capsule through the gastrointestinal tract. The average transit time from ingestion to evacuation is 24 hours. The device uses wireless radio transmission to send the images to a receiving recorder device that the patient wears around the waist. This receiving device also contains localizing antennae sensors that can roughly gauge where the image was taken over the abdomen. Images are then downloaded onto a workstation for viewing and processing.

CE has been proposed as a method for identifying Crohn disease. There is no single criterion standard diagnostic test for Crohn disease; rather, diagnosis is based on a constellation of findings. Thus it is difficult to determine the diagnostic characteristics of various tests used to diagnose the condition and difficult to determine a single comparator diagnostic test to CE.

Literature Review

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Suspected Small Bowel Bleeding

Clinical Context and Test Purpose

The purpose of wireless capsule endoscopy (CE) for patients who have suspected small bowel bleeding is to confirm a diagnosis and inform a decision to proceed to appropriate treatment.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with suspected small bowel bleeding?

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is patients with suspected small bowel bleeding. Suspected small bowel bleeding, previously referred to as obscure gastrointestinal (GI) tract bleeding, is defined as bleeding from the GI tract that persists or recurs without an obvious etiology after imaging with upper and lower endoscopy and radiologic evaluation of the small bowel. Recurrent or persistent iron-deficiency anemia, positive fecal occult blood test, or visible bleeding with no bleeding source found at original endoscopy are other indicators of obscure GI tract bleeding. Examples of etiologies for small bowel bleeding include angiodysplasia, tumor, medication-induced, infections, Crohn disease (CD), Meckel diverticulum, Zollinger-Ellison syndrome, vasculitis, radiation enteritis, jejunal diverticula, and chronic mesenteric ischemia.

Interventions

The intervention of interest is wireless CE.
Comparators
The following practice is currently being used to diagnose small bowel bleeding: a standard workup without wireless CE and, with or without direct endoscopic procedures or specialized GI imaging. A “true” reference standard for suspected small bowel bleeding is difficult or impossible to achieve because the bleeding source may resolve and invasive techniques (e.g., surgery) cannot be justifiably used.

Patients with suspected small bowel bleeding are actively managed by gastroenterologists and primary care providers in an outpatient setting.

Outcomes
The outcomes of interest for diagnostic accuracy include test validity (i.e., sensitivity, specificity). The primary outcomes of interest are symptoms and disease status that would change due to patient management decisions following wireless CE.

Wireless CE would be performed prior to surgical exploration if conventional endoscopy has been inconclusive. Follow-up for further diagnostic evaluation and surveillance for recurrence of symptoms would be immediate to weeks if no etiology is identified. Follow-up of weeks to months would be based on the disease condition identified by CE.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Systematic Reviews
Tables 2 and 3 summarize the characteristics and results of selected systematic reviews, which have evaluated a number of case series that compared the diagnostic accuracy of CE with alternative procedures such as intraoperative endoscopy or mesenteric angiography.

### Table 2. Characteristics of Systematic Reviews Evaluating CE for Iron-Deficient Anemia

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>Participants</th>
<th>N (Range)</th>
<th>Design</th>
<th>QUADAS Assessment of Included Trials</th>
</tr>
</thead>
</table>
Study | Dates | Trials | Participants | N (Range) | Design | QUADAS Assessment of Included Trials
--- | --- | --- | --- | --- | --- | ---
upper GI endoscopy prior to CE
CE: capsule endoscopy; GI: gastrointestinal; SBCE: small bowel capsule endoscopy.

### Table 3. Results of Systemic Reviews Evaluating CE for Iron-Deficient Anemia

<table>
<thead>
<tr>
<th>Study</th>
<th>Overall Diagnostic Yielda</th>
<th>Diagnostic Yield of Patients With IDA</th>
<th>P, %</th>
<th>Diagnostic Yield, n (%)c</th>
</tr>
</thead>
</table>
| Koulaouzidis et al (2012) | 1960 | 264 | • Angioectasias: 293 (45.9)
• Inflammatory lesions: 126 (19.7)
• Polyp/mass lesions: 42 (6.6)
• Not classified: 177 (27.7) |

Pooled effect (95% CI), %: 47 (42 to 52)
Diagnostic Yield, n (%): 66.6 (61.0 to 72.3)
Pooled effect, %: 78.8
p <0.001

CE: capsule endoscopy; CI: confidence interval; IDA: iron-deficient anemia.
a Per-patient analysis.
b From 4 studies (n=264 patients; 13.47% of total).
c Patients with positive SBCE findings.

### Randomized Controlled Trials

A small RCT compared CE with mesenteric angiography in patients with acute melena or hematochezia. While CE had a higher diagnostic yield, secondary outcomes such as transfusion, hospitalization, and mortality did not differ significantly between groups. Tables 4 and 5 summarize the characteristics and results of selected RCTs.

### Table 4. Characteristics of RCT Evaluating CE for Obscure GI Bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
</table>

CE: capsule endoscopy; GI: gastrointestinal; RCT: randomized controlled trial.

### Table 5. Results of RCT Evaluating CE for Obscure GI Bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>Diagnostic Yield (95% CI), %a</th>
<th>Rebleeding Rates (95% CI), %</th>
<th>Hospitalization Rate, n (%)</th>
<th>Transfusion Rate, n (%)</th>
<th>Mean Follow-Up (SD), mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leung et al (2012)</td>
<td>53.3 (36.1 to 69.8)</td>
<td>16.7 (7.3 to 33.6)</td>
<td>5 (16.7)</td>
<td>3 (10)</td>
<td>48.5 (20.9)</td>
</tr>
<tr>
<td>Angiography</td>
<td>20 (9.5 to 37.3)</td>
<td>33.3 (19.2 to 51.2)</td>
<td>5 (16.7)</td>
<td>3 (10)</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>33.3 (8.9 to 52.8)</td>
<td>16.7 (-5.3 to 36.8)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>
p | 0.016 | 0.23 | 1.0 |

CI: confidence interval; CE: capsule endoscopy; GI: gastrointestinal; RCT: randomized controlled trial; SD: standard deviation.
a Percentage identified with a high probability of bleeding.

The purpose of the limitations tables (see Tables 6 and 7) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

### Table 6. Study Relevance Limitations of RCT Evaluating CE for Obscure GI Bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
<th>Duration of Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leung et al (2012)</td>
<td>2. It is possible patients with moderate bleeding would not undergo angiography in clinical standard is lacking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon

Study | Population | Intervention | Comparator | Outcomes | Duration of Follow-Up
--- | --- | --- | --- | --- | ---
 | Setting | Study | setting | for evaluation of obscure GI bleeding | for evaluation of obscure GI bleeding | for evaluation of obscure GI bleeding

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

CE: capsule endoscopy; GI: gastrointestinal; RCT: randomized controlled trial.

a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
b Intervention key: 1. Classification thresholds not defined; 2. Version used unclear; 3. Not intervention of interest.
c Comparator key: 1. Classification thresholds not defined; 2. Not compared to credible reference standard; 3. Not compared to other tests in use for same purpose.
d Outcomes key: 1. Study does not directly assess a key health outcome; 2. Evidence chain or decision model not explicated; 3. Key clinical validity outcomes not reported (sensitivity, specificity, and predictive values); 4. Reclassification of diagnostic or risk categories not reported; 5. Adverse events of the test not described (excluding minor discomforts and inconvenience of venipuncture or noninvasive tests).
e Follow-Up key: 1. Follow-up duration not sufficient with respect to natural history of disease (true-positives, true-negatives, false-positives, false-negatives cannot be determined).

**Table 7. Study Design and Conduct Limitations of RCT Evaluating CE for Obscure GI Bleeding**

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation</th>
<th>Blinding</th>
<th>Selective Reporting</th>
<th>Follow-Up</th>
<th>Power</th>
<th>Statistical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leung et al (2012)</td>
<td>3. Study underpowered to detect significant difference in clinical outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

CE: capsule endoscopy; RCT: randomized controlled trial.

d Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

**Case Series**

Tables 8 and 9 summarize the characteristics and results of selected case series.

**Table 8. Characteristics of Case Series Evaluating CE for Obscure GI Bleeding**

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Participants</th>
<th>Treatment Delivery</th>
<th>Follow-Up (Range), mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartmann et al (2005)</td>
<td>Germany</td>
<td>47 patients &gt;18 y with obscure GI bleeding</td>
<td>Patients received CE and criterion standard, intraoperative endoscopy</td>
<td>NR</td>
</tr>
<tr>
<td>Pennazio et al (2004)</td>
<td>Italy</td>
<td>100 patients ≥18 y with obscure GI bleeding</td>
<td>51 patients received CE and PE before or after the procedure</td>
<td>Mean: 18 (5-25)</td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; GI: gastrointestinal; NR: not reported; PE: push enteroscopy.
Table 9. Results of Case Series Evaluating CE for ObSCure GI Bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Locating Bleeding With CE, %</th>
<th>Diagnostic Yield for Positive Lesions, %</th>
<th>PPV of CE, %</th>
<th>NPV of CE, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartmann et al (2005)</td>
<td>CE and intraoperative endoscopy</td>
<td>95</td>
<td>Both procedures: 76.6</td>
<td>95</td>
<td>86</td>
</tr>
<tr>
<td>Pennazio (2004)</td>
<td>CE and PE</td>
<td>89</td>
<td>67 (95% CI, 54 to 80)</td>
<td>97</td>
<td>82.6</td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; PPV: positive predictive value; NPV: negative predictive value; PE: push enteroscopy; CI: confidence interval

* CE results confirmed by intraoperative endoscopy or other reference standards.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Based on evidence that CE isolates the source of bleeding at least as well as other diagnostic tools and that few diagnostic options are available to patients with suspected small bowel bleeding, a chain of evidence can be constructed to support the clinical utility of CE for this indication.

Section Summary: Suspected Small Bowel Bleeding
A small RCT compared CE with mesenteric angiography in patients with acute melena or hematochezia. While CE had a higher diagnostic yield, secondary outcomes such as transfusion, hospitalization, and mortality did not differ significantly between groups. A large number of uncontrolled studies have evaluated the use of CE in the evaluation of patients with suspected small bowel bleeding. These studies have consistently reported that a substantial proportion of patients receive a definitive diagnosis following this test when there are few other diagnostic options. A meta-analysis of 24 studies estimated that the diagnostic yield in this patient population was approximately half of the included patients and was higher in patients with documented iron-deficiency anemia. CE appears to locate the source of bleeding at least as well as other diagnostic methods and direct treatment to the source of bleeding.

Suspected Crohn Disease
Clinical Context and Test Purpose
The purpose of wireless CE for patients with suspected CD is to confirm a diagnosis and inform a decision to proceed to appropriate treatment.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with suspected CD?

The following PICO was used to select literature to inform this review.
Populations
The relevant population of interest is individuals with suspected CD. CD is 1 of the 2 types of inflammatory bowel disease. Crohn disease can involve the entire GI tract and is characterized by transmural inflammation.

Interventions
The test being considered is wireless CE.

Patients with suspected CD are actively managed by gastroenterologists and primary care providers in an outpatient setting.

Comparators
The following tests are currently being used to diagnose CD: ileocolonoscopy, barium small bowel follow-through, computed tomography enterography (CTE), magnetic resonance enterography (MRE).

 Patients with suspected CD are actively managed by gastroenterologists and primary care providers in an outpatient setting.

Outcomes
The general outcomes of interest are test validity, other test performance measures, symptoms, and change in disease status.

The diagnosis of CD requires confirmatory imaging when the disease is prominent on the differential diagnosis list. The imaging study would be performed and promptly followed by appropriate treatment. CD is a chronic condition requiring long-term follow-up.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Results from a meta-analysis by Choi et al (2017), which compared CE with various modalities for diagnosing CD, are summarized in Tables 10 and 11. The reference standards varied for the selected studies, so quantitative data were not synthesized for diagnostic accuracy. In the pooled analysis, in patients with suspected CD, the sensitivity of CE ranged from 89.6% to 92.0% and the specificity was 100%.
Table 10. Characteristics of Systematic Reviews Assessing the Diagnostic Yield of CE vs Other Modalities

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>Participants</th>
<th>N (Range)</th>
<th>Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choi et al (2017)</td>
<td>2002-2013</td>
<td>24</td>
<td>Patients with suspected or established CD</td>
<td>NR</td>
<td>RCT, nonrandomized, and diagnostic accuracy studies</td>
</tr>
</tbody>
</table>

CD: Crohn disease; CE: capsule endoscopy; NR: not reported; RCT: randomized controlled trial.

Other modalities include small bowel follow-through, enteroclysis, computed tomography enterography, and magnetic resonance enterography.

Table 11. Results of Systematic Reviews Assessing the Diagnostic Yield of CE vs Other Modalities

<table>
<thead>
<tr>
<th>Study</th>
<th>CE vs SBFT</th>
<th>CE vs EC</th>
<th>CE vs CTE</th>
<th>CE vs MRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choi et al (2017)</td>
<td>66 vs 21.3</td>
<td>75.7 vs 29.4</td>
<td>72.5 vs 22.5</td>
<td>85.7 vs 100</td>
</tr>
<tr>
<td>Diagnostic yield, %</td>
<td>0.44 (0.29 to 0.59)</td>
<td>0.50 (0.21 to 0.79)</td>
<td>0.36 (0.18 to 0.90)</td>
<td>-0.16 (-0.63 to 0.32)</td>
</tr>
<tr>
<td>Weighted incremental yield (95% CI)</td>
<td>30</td>
<td>52</td>
<td>68</td>
<td>44</td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; CI: confidence interval; CTE: computed tomography enterography; EC: enteroclysis; MRE: magnetic resonance enterography; SBFT: small bowel follow-through.

From 4 studies (3 included in meta-analysis).

From 2 studies.

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Based on evidence that CE can provide a diagnosis of CD when other tests cannot, a chain of evidence can be constructed to support the clinical utility of CE for this indication.

Section Summary: Suspected Crohn Disease

For patients with suspected CD who cannot be diagnosed by other modalities, CE can confirm the diagnosis in a substantial number of patients.

Suspected Celiac Disease

Clinical Context and Test Purpose

The purpose of wireless CE for patients who have suspected celiac disease is to confirm a diagnosis and inform a decision to proceed to appropriate treatment.

The question addressed in this evidence review is: Does the use of CE endoscopy improve the net health outcome in patients with suspected celiac disease?

The following PICO was used to select literature to inform this review.
Populations
The relevant population of interest is individuals with suspected celiac disease. Celiac disease, or gluten-sensitive enteropathy, is an immune-mediated condition of the small intestine. Serologic markers of the disease have good sensitivity and specificity in triaging patients to endoscopy.

Interventions
The test being considered is wireless CE. CE has been evaluated as an alternative method of diagnosing celiac disease, assessing the extent of disease, and in the evaluation of celiac disease unresponsive to treatment.

Patients with suspected celiac disease are actively managed by gastroenterologists and primary care providers in an outpatient setting.

Comparators
The following test is currently being used to diagnose celiac disease: endoscopy with biopsy. The criterion standard for the diagnosis of celiac disease is obtained through small bowel biopsies obtained during endoscopy.

Patients with suspected celiac disease are actively managed by gastroenterologists and primary care providers in an outpatient setting.

Outcomes
The general outcomes of interest are test validity, other test performance measures, symptoms, and change in disease status.

The diagnosis of celiac disease requires confirmatory imaging when the disease is prominent on the differential diagnosis list. The imaging study would be performed and promptly followed by appropriate treatment. Celiac disease is a chronic condition requiring long-term follow-up.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Systematic Reviews
A meta-analysis by El-Matary et al (2009) compared the diagnostic performance of CE with a reference standard of duodenal biopsy. The pooled analysis of 3 studies showed a sensitivity of
83% and a specificity of 98%. Another meta-analysis by Rokkas and Niv (2012) also compared the diagnostic performance of CE with biopsy, summarizing 6 studies (total n=166 subjects). The overall pooled sensitivity was 89% and the specificity was 95%.

CE detected involvement of intestines beyond the duodenum; however, the clinical significance of detecting the extent of celiac disease is uncertain. Given the less than 90% sensitivity of CE for celiac disease, it does not appear to be an adequate alternative method of making an initial diagnosis.

Nonrandomized Studies
In a study by Kurien et al (2013), 62 patients with an equivocal diagnosis of celiac disease and 69 patients with the confirmed celiac disease who were unresponsive to standard treatment were evaluated with CE. Results were combined with human leukocyte antigen typing and response to gluten challenge, with the final diagnosis made by 3 expert physicians who received the information from all 3 sources. The main outcome was the increase in diagnostic yield after CE combined with the other tests. The diagnostic yield was greatest in cases with antibody-negative villous atrophy where a diagnosis of celiac disease was made in 9 (28%) of 32 patients. In 8 (12%) of the 69 nonresponsive celiac disease patients, CE identified 2 cases of enteropathy-associated lymphoma, 4 type 1 refractory disease cases, 1 fibroepithelial polyp, and 1 case of ulcerative jejunitis. This study was limited by the small sample size and use of other tests in conjunction with CE to ascertain a final diagnosis.

The role of CE in nonresponsive celiac disease has been evaluated in only a few studies. One case series by Culliford et al (2005) evaluated 47 patients with complicated celiac disease and found unexpected additional findings in 60% of patients, most of which were ulcerations. However, the definition of “complicated” celiac disease included other factors such as evidence of blood loss, itself an indication for CE. The impact on patient management and outcomes is unclear.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for diagnosing celiac disease has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

Section Summary: Suspected Celiac Disease
In cases where the diagnosis of celiac disease is equivocal, CE can sometimes reveal morphologic changes in the small bowel consistent with celiac disease. However, it is unlikely that the appearance of small bowel on CE is itself sufficient to make a definitive diagnosis of celiac disease. Small bowel biopsy, celiac serologies, and human leukocyte antigen typing remain the standard tests for confirming celiac disease and have a higher sensitivity and
specificity for this purpose. Case series of patients with unresponsive celiac disease undergoing CE have shown some yield of actionable diagnoses that have the potential to improve patient outcomes. Larger studies are needed to better determine the diagnostic yield of CE in these patients.

**Unexplained Chronic Abdominal Pain**

**Clinical Context and Test Purpose**

The purpose of wireless CE for patients who have unexplained chronic abdominal pain is to confirm a diagnosis and inform a decision to proceed to appropriate treatment.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with unexplained chronic abdominal pain?

The following PICO was used to select literature to inform this review.

**Populations**

The relevant population of interest is individuals with unexplained chronic abdominal pain.

**Interventions**

The test being considered is wireless CE.

Patients with unexplained chronic abdominal pain are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Comparators**

The following practice is currently being used to diagnose chronic abdominal pain: standard workup for abdominal pain without CE.

Patients with unexplained chronic abdominal pain are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Outcomes**

The general outcomes of interest are test validity, other test performance measures, symptoms, and change in disease status.

The diagnosis of chronic abdominal pain is often one of exclusion after a comprehensive clinical evaluation including empirical treatment. Imaging studies are used during initial and follow-up evaluations. Continued follow-up would be based on a definitive or working diagnosis, which would typically occur over weeks to months.

**Technically Reliable**

Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

**Study Selection Criteria**

Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
If the test is intended to replace or be an adjunct to an existing test, it should also be compared with that test.

Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.

Studies should also report reclassification of the diagnostic or risk category.

**Systematic Reviews**

Xue et al (2015) reported on a systematic review of 21 studies (total N=1,520 patients) evaluating CE for unexplained chronic abdominal pain. The pooled diagnostic yield was 20.9% (95% CI, 15.9% to 25.9%). The most commonly identified findings were inflammatory lesions (78.3%) and tumors (9.0%). Studies in the review were highly heterogeneous. Limitations in interpreting the findings included retrospective study designs, different durations of abdominal pain, and the use of different tests before CE.

**Case Series**

In a study not included in the systematic review, Yang et al (2014) reported on a case series evaluating 243 patients with CE for unexplained chronic abdominal pain. The diagnostic yield of CE was 23.0%. Identified findings included 19 (7.8%) patients with CD, 15 (6.2%) with enteritis, 11 (4.5%) with idiopathic intestinal lymphangiectasia, 5 (2.1%) with unciniarisis, 5 (2.1%) with abnormal transit time and other findings (e.g., small bowel tumor, ascariasis, anaphylactoid purpura).

**Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for diagnosing unexplained chronic abdominal pain has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

**Section Summary: Unexplained Chronic Abdominal Pain**

While CE diagnosed unexplained chronic abdominal pain in a proportion of patients reported in retrospective studies, the sequence and chronology of testing and treatment recommended before CE needs to be defined to determine whether CE had utility to diagnose the condition.

**Established Crohn Disease**

**Clinical Context and Test Purpose**

The purpose of wireless CE for patients who have established diagnosis of CD is to inform management decisions based on disease status.
The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients diagnosed with CD?

The following PICO was used to select literature to inform this review.

**Populations**
The relevant population of interest is patients with CD.

**Interventions**
The intervention of interest is wireless CE.

Patients with an established diagnosis of Crohn disease are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Comparators**
The following test is currently being used to monitor CD: ileocolonoscopy, barium small bowel follow-through, CTE, and MRE.

An international consensus statement indicated that radiographic imaging should take precedence over CE because of the capability to detect obstructive strictures as well as extraluminal and transmural disease. The consensus statement identified some studies in which CE had a higher percentage of positive findings than alternative tests in patients with established CD, but it is not clear how these findings correlated with either symptoms or outcomes of the therapeutic intervention. A 2013 European consensus statement indicated MRE or CTE is usually preferred to CE in patients with known CD patients. The 2013 consensus also indicated CE should be limited in patients with CD to the evaluation of unexplained symptoms, unexplained iron-deficiency, or obscure GI bleeding after other investigations are inconclusive.

Patients with an established diagnosis of Crohn disease are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Outcomes**
The beneficial outcome of a true test result, if correctly classified as low disease activity, is the avoidance of endoscopy and unnecessary medications.

Wireless CE would be performed to monitor patients with CD.

**Technically Reliable**
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

**Study Selection Criteria**
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
• Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
• Studies should also report reclassification of the diagnostic or risk category.

**Systematic Reviews**
Kopylov et al (2017) published a systematic review of studies evaluating the use of CE for CD. Studies evaluated prospective studies comparing CE with MRE and/or small bowel contrast ultrasound in patients who had suspected and/or established CD. In pooled analyses of the 11 studies that included patients with established CD, the diagnostic yield of CE was similar to that of MRE (odds ratio [OR], 1.88; 95% CI, 0.53 to 1.48; I²=48%) and ultrasound (OR=0.57; 95% CI, 0.27 to 1.20; I²=67%).

**Diagnostic Accuracy Studies**
Bruining et al (2020) reported results from the multicenter, prospective BLINK trial comparing the diagnostic accuracy of CE compared to ileocolonoscopy (IC) and/or magnetic resonance enterography (MRE) in patients with established CD. The per-protocol analysis included 99/158 enrolled subjects with 16 patients tested by all 3 modalities. Major reasons for exclusion from analysis included patency failure or MRE stricture and major protocol violations. The reference standard was defined as the presence or absence of inflammation as designated by the modality-specific scoring system at prospective interpretation by expert central readers. In cases of discrepant findings for any bowel segment, all modalities were reviewed and resolved by a consensus panel consisting of 3 gastroenterologists. Overall sensitivity, specificity, PPV, and NPV were 94% (95% CI, 86 to 98%), 74% (95% CI, 55 to 87%), 91% (95% CI, 82 to 96%), 83% (95% CI, 64 to 94%) for CE compared to 100% (95% CI, 95 to 100%), 22% (95% CI, 10 to 41%), 77% (95% CI, 68 to 85%), and 100% (95% CI, 54 to 100) for IC and/or MRE. Sensitivity of CE was significantly higher compared to MRE for enteric inflammation in the proximal small bowel (97% vs 71%, P=0.021) and similar in the terminal ileum and colon (P=0.500-0.625). Discrepant reads between the proximal small bowel, terminal ileum, and colon were 57%, 49%, and 81%, respectively. In the proximal small bowel, the majority consensus panel decision was agreement with CE.

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**
Indirect evidence of clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Based on evidence that CE has a similar diagnostic yield as radiography when used to monitor CD and CE can be used when radiography cannot, a chain of evidence can be constructed to support the clinical utility of CE for this indication.

**Section Summary: Established Crohn Disease**
A 2017 systematic review of 11 studies in patients with established CD found a similar diagnostic yield with CE compared with radiography. A diagnostic accuracy study of CE compared with IC
Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon

Page 17 of 57

and/or MRE for the detection of active inflammatory CD in patients with established CD found a comparable sensitivity, higher specificity and PPV, and lower NPV compared to IC and/or MRE. Differences may be attributed to high rates of discrepant reads between modalities and high consensus panel agreement with CE results in cases of discrepancy. International consensus statements have suggested that radiographic imaging has advantages (e.g., ability to detect obstructive strictures) and that CE should be limited to certain situations (e.g., unexplained symptoms or other inconclusive investigations).

**Ulcerative Colitis**

Ulcerative colitis is an inflammatory disease of the large intestine. CE has been proposed as an alternative method for assessing the extent and severity of disease activity in those with known ulcerative colitis.

**Clinical Context and Test Purpose**

The purpose of wireless CE for patients who have ulcerative colitis is to inform management decisions based on disease status.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with ulcerative colitis?

The following PICO was used to select literature to inform this review.

**Populations**

The relevant population of interest is individuals with ulcerative colitis.

**Interventions**

The test being considered is wireless CE.

Patients with ulcerative colitis are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Comparators**

The following test is currently being used to manage ulcerative colitis: optical colonoscopy. Patients with ulcerative colitis are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Outcomes**

The general outcomes of interest are test validity, other test performance measures, symptoms, and change in disease status.

Wireless CE would be performed to monitor patients after a confirmed diagnosis of ulcerative colitis.

**Technically Reliable**

Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

**Study Selection Criteria**

Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.
The study population represents the population of interest. Eligibility and selection are described.

The test is compared with a credible reference standard.

If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.

Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.

Studies should also report reclassification of the diagnostic or risk category.

A number of prospective observational studies have evaluated the diagnostic accuracy of CE in patients with ulcerative colitis. Tables 12 and 13 summarize the characteristics and results of these studies.

Table 12. Characteristics of Observational Comparative Studies Assessing CE for UC

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Country</th>
<th>Dates</th>
<th>Participants</th>
<th>Treatment</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Juan-Acosta et al (2014)</td>
<td>Single-blind prospective comparative</td>
<td>Spain</td>
<td>2010-2012</td>
<td>Patients 18-70 y with UC with flare in disease activity or due for CRC screening</td>
<td>23 underwent CE-1, 19 had CE-2; all followed by colonoscopy</td>
<td>NR</td>
</tr>
<tr>
<td>Oliva et al (2014)</td>
<td>Prospective observational</td>
<td>Spain</td>
<td>2011-2012</td>
<td>Patients 6-18 y with a diagnosis at least 3 mo prior to enrollment</td>
<td>30 patients underwent CE-2, followed by colonoscopy</td>
<td>NR</td>
</tr>
<tr>
<td>Sung et al (2012)</td>
<td>Prospective cohort</td>
<td>China and Singapore</td>
<td>2000-2008</td>
<td>Patients with suspected or known UC</td>
<td>100 patients underwent CE and same-day colonoscopy</td>
<td>NR</td>
</tr>
</tbody>
</table>

CE-1: first-generation capsule endoscopy; CE-2: second-generation capsule endoscopy; CRC: colorectal cancer; NR: not reported; UC: ulcerative colitis.

Table 13. Results of Observational Comparative Studies Assessing CE for Ulcerative Colitis

<table>
<thead>
<tr>
<th>Study</th>
<th>Active Colonic Inflammation, %</th>
<th>PPV, %</th>
<th>NPV, %</th>
<th>Correlation Between Colon CE and Colonoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sensitivitya</td>
<td>Specificity</td>
<td></td>
<td>Disease Severity</td>
</tr>
<tr>
<td>Shi et al (2017)</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Mucosal inflammation (MES &gt;0)</td>
<td>97</td>
<td>94-95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M-to-S inflammation (MES &gt;1)</td>
<td>94</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postinflammatory polyps</td>
<td>100</td>
<td>91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICC (95% CI)</td>
<td>0.69 (0.46 to 0.81)a</td>
<td>0.64 (0.38 to 0.78)b</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>San Juan-Acosta et al (2014)</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>CE vs colonoscopy</td>
<td>Disease activity</td>
<td>77.78</td>
<td>95.83</td>
<td>93.33</td>
</tr>
<tr>
<td></td>
<td>Disease extent</td>
<td>68.75</td>
<td>96.15</td>
<td>91.67</td>
</tr>
<tr>
<td></td>
<td>κ (95% CI)</td>
<td>0.79 (0.62 to 0.96)</td>
<td>0.71 (0.52 to 0.90)</td>
<td></td>
</tr>
<tr>
<td>Oliva et al (2014)</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Active Colonic Inflammation, % (95% CI)</td>
<td>PPV, % (95% CI)</td>
<td>NPV, % (95% CI)</td>
<td>Correlation Between Colon CE and Colonoscopy % (95% CI)</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Sung et al (2012)</td>
<td>96 (79 to 99)</td>
<td>100 (61 to 100)</td>
<td>85 (49 to 97)</td>
<td>96 (79 to 99)</td>
</tr>
<tr>
<td>N</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; CI: confidence interval; ICC: intraclass correlation coefficient; MES: Mayo Endoscopic Subscore; M-to-S: moderate to severe; NPV: negative predictive value; PPV: positive predictive value.

Sung et al (2012) evaluated 100 patients with colon cancer and compared the diagnostic accuracy of colonoscopy and colon CE. The study found that colon CE had a sensitivity of 96% (95% CI: 79 to 99) and a specificity of 100% (95% CI: 61 to 100). The diagnostic accuracy of colonoscopy was 100% (95% CI: 85 to 100). The correlation between colon CE and colonoscopy was 96% (95% CI: 79 to 99). The PPV of colon CE was 100% (95% CI: 85 to 100) and the NPV was 85% (95% CI: 49 to 97). The study concluded that colon CE is an accurate and reliable diagnostic tool for colon cancer.

In the study by Sung et al (2012), although the correspondence between the 2 methods was reasonably good, it is uncertain whether management changes based on 1 or the other test would result in similar or different patient outcomes.

Oliva et al (2014) evaluated 30 patients with known ulcerative colitis with both CE and colonoscopy to assess disease activity. The reference standard for disease activity was a Matts score greater than 6 as judged by colonoscopy. Although the 2 methods had a high concordance at this cutoff level of disease in this study, patient outcomes linked to these assessments of disease activity cannot be determined.

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility. Because the clinical validity of wireless CE for monitoring ulcerative colitis has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

**Section Summary: Ulcerative Colitis**
Several diagnostic accuracy studies have compared CE with colonoscopy to assess disease activity in patients with ulcerative colitis. Two of 4 studies were small (i.e., <50 patients) and thus data on diagnostic accuracy are limited. Because there are insufficient data on diagnostic accuracy, a chain of evidence on clinical utility cannot be constructed.

**Esophageal Disorders**
**Clinical Context and Test Purpose**
The purpose of wireless CE for patients who have esophageal disorders is to inform management decisions based on disease status.
The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with esophageal disorders?

The following PICO was used to select literature to inform this review.

**Populations**
The relevant population of interest is individuals with esophageal disorders. Gastrointestinal reflux disease and chronic sequelae such as Barrett esophagus may require diagnostic and surveillance interventions.

**Interventions**
The test being considered is wireless CE. In the esophagus, the capsule camera has been proposed as a screening technique for Barrett esophagus associated with gastroesophageal reflux disease. Evaluation of the esophagus requires limited transit time, and it is estimated that the test takes 20 minutes to perform.

CE can visualize several types of esophageal conditions. It could substitute for traditional upper endoscopy for several indications and may have the advantage of comfort and convenience. However, interventional procedures and biopsies cannot be performed with CE. CE could triage patients for endoscopy if either the sensitivity or the specificity is high. Traditional endoscopy could then be performed on the appropriate group to determine false-positives or false-negatives, having spared the group with a high positive predictive value an endoscopy procedure.

Patients with esophageal disorders are actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Comparators**
The following test is currently being used to manage esophageal disorders: upper GI endoscopy.

**Outcomes**
The general outcomes of interest are test validity, other test performance measures, symptoms, and change in disease status.

Wireless CE would be performed to monitor patients after a confirmed diagnosis of an esophageal disorder.

**Technically Reliable**
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

**Study Selection Criteria**
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.

Studies should also report reclassification of the diagnostic or risk category.

Most studies have shown that CE has inferior diagnostic characteristics compared with traditional upper endoscopy for a variety of esophageal conditions. A meta-analysis by Guturu et al (2011) evaluated 9 studies comparing CE with traditional endoscopy for detecting esophageal varices and calculated a sensitivity of 83% and specificity of 85%.20 A meta-analysis by Bhardwaj et al (2009) assessed 9 studies comparing CE with traditional endoscopy for detecting Barrett esophagus and reported a sensitivity of 77% and specificity of 86%.21 Because of the lower sensitivity and specificity of that test, CE cannot substitute for traditional endoscopy nor can it be used to triage patients to endoscopy.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for monitoring esophageal disorders has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

Section Summary: Esophageal Disorders
Other available modalities are superior to CE for monitoring esophageal disorders. The diagnostic characteristics of CE are inadequate to substitute for other modalities or to triage patients to other modalities.

Hereditary GI Polyposis Syndromes
Clinical Context and Test Purpose
The purpose of wireless CE for patients who have hereditary GI polyposis syndromes is to inform management decisions based on disease status.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with hereditary GI polyposis syndromes?

The following PICO was used to select literature to inform this review.

Populations
The relevant population of interest is individuals with hereditary GI polyposis syndromes, including Lynch syndrome and Peutz-Jeghers syndrome (PJS).
Interventions
The test being considered is wireless CE.

Patients with hereditary GI polyposis syndromes are actively managed by gastroenterologists and primary care providers in an outpatient setting.

Comparators
The following tests and practices are currently being used to manage hereditary GI polyposis syndromes: ileocolonoscopy, barium small bowel follow-through, CTE, and MRE, which are performed by a gastroenterologist in an outpatient setting.

Outcomes
The general outcomes of interest are, test validity, other test performance measures, symptoms, and change in disease status.

Wireless CE would be performed to monitor patients after a confirmed diagnosis with hereditary GI polyposis syndromes.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Persons with familial adenomatous polyposis and PJS are genetically at high-risk of small bowel polyps and tumors. Urquhart et al (2014) compared CE with MRE in 20 patients with PJS. CE identified more polyps 10 mm or larger (47 polyps) than MRE (14 polyps; p=0.02). However, subsequent balloon enteroscopy in 12 patients showed a poor correlation of findings between techniques, with a 100% positive predictive value of finding a polyp on balloon enteroscopy with MRE vs 60% for CE. A study by Brown et al (2006) in 19 patients showed a greater number of polyps identified with CE than with barium follow-through examinations. Mata et al (2005) studied the role of CE in 24 patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis (n=20) or PJS (n=4). Compared with barium studies using small bowel enteroclysis, CE identified 4 additional patients with small bowel polyps, which were subsequently removed with endoscopic polypectomy. Although these studies were small, they demonstrated that CE can identify additional lesions compared with other diagnostic methods in persons with disease syndromes at high-risk for such lesions.
The lifetime risk of small bowel cancer in Lynch syndrome has been estimated at 5%. Although not extremely high, this risk is greatly increased compared with the general population. There are a few case series of the prevalence of neoplastic lesions in asymptomatic patients with Lynch syndrome. Haanstra et al (2015), 200 patients with Lynch syndrome underwent CE. Small bowel neoplasia was detected in the duodenum in 2 patients (1 adenocarcinoma, 1 adenoma). These lesions would have been in the reach of a gastroduodenoscope. In a smaller study by Saurin et al (2010), 35 asymptomatic patients with Lynch syndrome underwent colon CE. Small bowel neoplasms were diagnosed in 3 (8.6%) patients (1 adenocarcinoma, 2 adenomas with low-grade dysplasia).

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for monitoring hereditary GI polyposis syndromes has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

**Section Summary: Hereditary GI Polyposis Syndromes**
Although studies have shown at least a low prevalence of small bowel neoplasms, these data are insufficient to determine whether evaluation with CE would improve patient outcomes. Additional data on the prevalence and natural history of small bowel polyps in Lynch syndrome patients are necessary. At this time, surveillance of the small bowel is not generally recommended as a routine intervention for patients with Lynch syndrome.

**Portal Hypertensive Enteropathy**
Patients with liver cirrhosis and portal hypertension can develop portal hypertensive enteropathy, which may lead to GI bleeding. CE has been considered as a diagnostic tool for portal hypertensive enteropathy.

**Clinical Context and Test Purpose**
The purpose of wireless CE for patients who have portal hypertensive enteropathy is to inform management decisions based on disease status.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with portal hypertensive enteropathy?

The following PICO was used to select literature to inform this review.

**Populations**
The relevant population of interest is individuals with portal hypertensive enteropathy.
Interventions
The test being considered is wireless CE, which is performed in an outpatient setting by a gastroenterologist.

Comparators
The following test is currently being used to manage portal hypertensive enteropathy: upper and lower endoscopy, which are performed in an outpatient setting by a gastroenterologist.

Outcomes
The general outcomes of interest are test validity, other test performance measures, symptoms, and change in disease status.

Wireless CE would be performed to monitor patients after a confirmed diagnosis with portal hypertensive enteropathy.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Several systematic reviews, including a Cochrane review, have been published. Tables 14 and 15 summarize the characteristics and results of select systematic reviews.

Table 14. Characteristics of Systematic Reviews Assessing CE for Portal Hypertensive Enteropathy

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>Participants</th>
<th>N (Range)</th>
<th>Design</th>
</tr>
</thead>
</table>

NR: not reported.

Table 15. Results of Systematic Reviews Assessing CE for Portal Hypertensive Enteropathy

<table>
<thead>
<tr>
<th>Study</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive</th>
<th>Negative</th>
<th>CE</th>
<th>Diagnostic Accuracy Medium-to-Large Varices</th>
</tr>
</thead>
<tbody>
<tr>
<td>McCarty et al (2017)27</td>
<td>N = 1328</td>
<td>83 (76 to 89)</td>
<td>85 (75 to 91)</td>
<td>5.4 (3.3 to 9.0)</td>
<td>0.20 (0.14 to 0.28)</td>
<td>90 (88 to 93)</td>
</tr>
<tr>
<td>PE (95% CI), %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Studies with low risk of bias, n</td>
<td>PE (95% CI), %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE (95% CI), %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colli et al (2014)28</td>
<td>N = 936</td>
<td>80 (81 to 88)</td>
<td>86 (68 to 94)</td>
<td>85 (81 to 88)</td>
<td>92 (89 to 94)</td>
<td>936</td>
</tr>
<tr>
<td>Study</td>
<td>CE, %</td>
<td>Likelihood Ratios</td>
<td>Diagnostic Accuracy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>-------------------</td>
<td>---------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE (95% CI), %</td>
<td>84.8 (77.3 to 90.2)</td>
<td>5.4 (3.1 to 9.5)</td>
<td>0.18 (0.12 to 0.27)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Studies with low risk of bias, n</td>
<td>396</td>
<td>396</td>
<td>396</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE (95% CI), %</td>
<td>79.7 (73.1 to 85.0)</td>
<td>5.8 (2.1 to 16.1)</td>
<td>0.24 (0.18 to 0.31)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CI: confidence interval; CE: capsule endoscopy; PE: pooled effect.

**Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for monitoring portal hypertensive enteropathy has not been established, a chain of evidence supporting the test's clinical utility for this indication cannot be constructed.

**Section Summary: Portal Hypertensive Enteropathy**

CE has been used to diagnose portal hypertensive enteropathy. Systematic reviews of studies of its diagnostic performance have reported limited sensitivity and specificity. Because neither the sensitivity nor the specificity was high for identifying esophageal varices, CE should not be used instead of esophagogastroduodenoscopy nor should it be used to triage patients to esophagogastroduodenoscopy. Based on these diagnostic characteristics, the test does not appear to have clinical utility.

**Acute Upper GI Tract Bleeding**

**Clinical Context and Test Purpose**

The purpose of wireless CE for patients who have acute upper GI tract bleeding is to inform management decisions based on disease status.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with acute upper GI tract bleeding?

The following PICO was used to select literature to inform this review.

**Populations**

The relevant population of interest is patients with acute GI tract bleeding.

**Interventions**

The intervention of interest is wireless CE.

The test would be performed in an urgent care or emergency department setting.
Comparators
The following practices are currently being used to manage acute upper GI tract bleeding: standard workup of acute bleeding without wireless CE and, with or without direct endoscopic procedures or specialized GI imaging.

The tests would be performed in an urgent care or emergency department setting.

Outcomes
The primary outcomes of interest for clinical utility are symptoms and disease status that would change due to patient management decisions following wireless CE. Other outcomes of interest are the avoidance of hospitalizations and reductions in resource utilization (e.g., need for additional testing or procedures).

Wireless CE would be performed as soon as possible after acute bleeding is identified. Wireless CE would be performed to monitor patients after a confirmed diagnosis with acute GI tract bleeding.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operating curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Randomized Controlled Trials
Sung et al (2016) reported on a prospective RCT to evaluate the use of CE in the emergency department for patients with suspected upper GI bleeding. CE was used to determine whether patients would be admitted to the hospital or sent home, vs an alternative strategy of admitting all patients. Eligible patients presented with signs and/or symptoms of acute upper GI bleeding but were without hemodynamic shock or conditions likely to preclude the use of the capsule endoscope. Seventy-one patients were randomized to CE in the emergency department (n=37), followed by monitoring for upper GI bleeding, or standard care (n=34), which included mandatory hospital admission. Seven CE patients with active bleeding or endoscopic findings were admitted, with the remainder discharged home. There were no deaths or morbid outcomes in either group, indicating that CE could result in equivalent patient outcomes with many patients safely avoiding emergency hospitalization.

Tables 16 and 17 summarize the characteristics and results of select RCTs.
Table 16. Characteristics of RCTs Assessing CE for Acute GI Tract Bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sung et al (2016)</td>
<td>China</td>
<td>NR</td>
<td>2013-2014</td>
<td>Patients presenting to ED with symptoms suggestive of UGIB</td>
<td>37 randomized to CE; admission determined by CE</td>
<td>34 randomized to SOC; admission determined by GBS</td>
</tr>
<tr>
<td>Gutkin et al (2013)</td>
<td>U.S.</td>
<td>3</td>
<td>NR</td>
<td>Patients ≥18 y with history suggestive of acute UGIB ≤48 h prior to ED presentation</td>
<td>12 randomized to VCE prior to endoscopy</td>
<td>12 randomized to endoscopy</td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; ED: emergency department; GI: gastrointestinal; GBS: Glasgow Blatchford score; NR: not reported; RCT: randomized controlled trial; SOC: standard of care; UGIB: upper gastrointestinal bleeding; VCE: video capsule endoscopy.

Table 17. Results of RCTs Assessing CE for Acute GI Tract Bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>Active Bleeding or Endoscopic Findings, n</th>
<th>Hospitalization, n</th>
<th>Mortality, n</th>
<th>GBS Score</th>
<th>Agreement Between CE and EGD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sung et al (2016)</td>
<td>CE</td>
<td>“Coffee ground” material: 2</td>
<td>68</td>
<td>0</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>VCE</td>
<td>8 (67.7%) had positive findings confirmed by endoscopy; for these patients, average Rockall score was 3; average Blatchford score was 13</td>
<td>24</td>
<td>24</td>
<td>VCE data identical to EGD results (P=1.0)</td>
</tr>
<tr>
<td>Gutkin et al (2013)</td>
<td>SOC</td>
<td>Peptic ulcer: 14</td>
<td>34</td>
<td>0</td>
<td>No patients scored 0</td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; EGD: esophagogastroduodenoscopy; GI: gastrointestinal; GBS: Glasgow Blatchford score; RR: relative risk; SOC: standard of care; VCE: video capsule endoscopy.

The purpose of the limitations tables (see Tables 18 and 19) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

Table 18. Study Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
<th>Duration of Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sung et al (2016)</td>
<td>a</td>
<td>b</td>
<td>c</td>
<td>d</td>
<td>e</td>
</tr>
<tr>
<td>Gutkin et al (2013)</td>
<td>a</td>
<td>b</td>
<td>c</td>
<td>d</td>
<td>e</td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon

Page 28 of 57

a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
b Intervention key: 1. Classification thresholds not defined; 2. Version used unclear; 3. Not intervention of interest.
c Comparator key: 1. Classification thresholds not defined; 2. Not compared to credible reference standard; 3. Not compared to other tests in use for same purpose.
d Outcomes key: 1. Study does not directly assess a key health outcome; 2. Evidence chain or decision model not explicated; 3. Key clinical validity outcomes not reported (sensitivity, specificity, and predictive values); 4. Reclassification of diagnostic or risk categories not reported; 5. Adverse events of the test not described (excluding minor discomforts and inconvenience of venipuncture or noninvasive tests).
e Follow-Up key: 1. Follow-up duration not sufficient with respect to natural history of disease (true-positives, true-negatives, false-positives, false-negatives cannot be determined).

Table 19. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Selectiona</th>
<th>Blindingb</th>
<th>Delivery of Testc</th>
<th>Selective Reportingd</th>
<th>Data Completenessa</th>
<th>Statisticalf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sung et al (2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. As a feasibility study, confidence intervals and p values were not reported</td>
</tr>
<tr>
<td>Gutkin et al (2013)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Small sample size based on pilot/feasibility study</td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

a Selection key: 1. Selection not described; 2. Selection not random or consecutive (i.e., convenience).
b Blinding key: 1. Not blinded to results of reference or other comparator tests.
c Test Delivery key: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.
e Data Completeness key: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to follow-up or missing data.
f Statistical key: 1. Confidence intervals and/or p values not reported; 2. Comparison with other tests not reported.

Cohort Studies
Two 2013 studies with small cohorts of patients (range, 49-83 patients) have reported on the use of CE before upper endoscopy for acute GI bleeding, to triage and/or risk-stratify patients in the emergency department or hospital. These studies reported that CE provides useful information, such as identifying gross bleeding and inflammatory lesions in a substantial proportion of patients and in stratifying patients into high- or low-risk categories. However, the yield of CE in localizing the bleeding source was lower than for esophagogastroduodenoscopy, which is the standard initial evaluation for acute upper GI bleeding.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.
Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to
demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for diagnosing acute upper GI tract bleeding has not
been established, a chain of evidence supporting the test’s clinical utility for this indication
cannot be constructed.

Section Summary: Acute Upper GI Tract Bleeding
Use of CE in the emergency department setting for suspected upper GI bleeding is based on
efficiency (avoiding hospitalization, avoiding immediate endoscopy). Controlled studies are
needed to assess further the impact of CE on health outcomes compared with standard
management. Patients should be followed to their ultimate diagnosis to determine whether the
use of CE vs other triage strategies or immediate endoscopy results in lower health care resource
utilization.

Colon Cancer Screening
Clinical Context and Test Purpose
The purpose of wireless CE for patients who are being screened for colon cancer is to confirm a
diagnosis and inform a decision to proceed to appropriate treatment.

The question addressed in this evidence review is: Does the use of wireless CE improve the net
health outcome in patients undergoing colon cancer screening?

The following PICO was used to select literature to inform this review.

Populations
The relevant population of interest is patients who are undergoing colon cancer screening.

Interventions
The intervention of interest is wireless CE, which is performed by gastroenterologists in an
outpatient setting. Patients screened for colon cancer are actively managed by oncologists,
gastroenterologists, radiologists, surgeons, and primary care providers in an outpatient setting.

Comparators
The following test is currently being used to diagnose colon cancer: standard workup using
optical colonoscopy, which is performed by gastroenterologists in an outpatient setting. Patients
screened for colon cancer are actively managed by oncologists, gastroenterologists,
radiologists, surgeons, and primary care providers in an outpatient setting.

Outcomes
The outcomes of interest for diagnostic accuracy include test validity (i.e., sensitivity, specificity).
The primary outcomes of interest for clinical utility are overall mortality and disease-specific
mortality from colon cancer.

Wireless CE would be performed after an initial clinical examination. Though not completely
standardized, follow-up for screening for colon cancer would be based on guidelines for
asymptomatic screening or for follow-up of significant screening findings.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review
of unpublished and often proprietary information. Review of specific tests, operators, and
unpublished data are outside the scope of this evidence review and alternative sources exist.
This evidence review focuses on the clinical validity and clinical utility.
Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

Several studies have assessed the accuracy of CE for detecting colonic lesions. Spada et al (2016) reported on a systematic review and meta-analysis of the diagnostic accuracy of CE for detecting colorectal polyps with stratified results for first- and second-generation capsules.33 Across the 14 eligible studies, the indications for endoscopy included colorectal cancer screening (n=1261 [47%]), postpolypectomy surveillance or family history of colorectal cancer (n=636 [24%]), symptoms suggestive of cancer and/or fecal occult blood test positivity (n=619 [23%]), positive imaging tests (n=136 [5%]), or other indication (24 [1%]). There were no missed cancers (n=11) in the series using second-generation CE (per-patient sensitivity, 100%). In series using the first-generation CE, 6 of 26 proven cancers were missed on CE (per-patient sensitivity, 77%).

Kjolhede et al (2020) reported on a systematic review and meta-analysis of the diagnostic accuracy of CE compared to colonoscopy with stratified results for polyps of any size, polyps ≥ 6mm, and polyps ≥ 10 mm.34 Across analyzed patients in the 12 eligible studies, the indications for endoscopy included colorectal cancer screening or history of polyps or colorectal cancer (n=1200 [63.2%]), positive fecal immunochemical test (n=493 [26%]), first-degree relatives of patients with colorectal cancer (n=177 [9.3%]), or unspecified (n=28 [1.5%]). The rate of patients with an adequate bowel preparation ranged from 40% to 100%. The rates of complete CE transits ranged from 57% to 100%. The authors note that the relatively high rate of incomplete CE investigations limits the utility of CE in the colorectal cancer setting. All but 1 study was assessed to have a high risk of bias and applicability concerns for the reference standard.

Characteristics of the systematic reviews and their main findings are summarized in Tables 20 and 21, respectively.

### Table 20. Characteristics of Systematic Review Assessing CE for Colon Cancer Screening

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>N (Range)</th>
<th>Design</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kjolhede et al (2020)34</td>
<td>2009-2020</td>
<td>12</td>
<td>2199 (20-884)</td>
<td>Diagnostic accuracy studies</td>
<td>Per-patient sensitivity of CCE for various polyp size thresholds</td>
</tr>
</tbody>
</table>

CCE: colon capsule endoscopy.

### Table 21. Results of Systematic Review Assessing CE for Colon Cancer Screening

<table>
<thead>
<tr>
<th>Random-Effects Model</th>
<th>Trials</th>
<th>N</th>
<th>Outcomes</th>
<th>Effect Size</th>
<th>95% CI</th>
<th>P, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spada et al (2016)33</td>
<td>For ≥10 mm polyps</td>
<td>10</td>
<td>NR</td>
<td>Sens=80.0% Spec=96.2%</td>
<td>66% to 90.3% 94.0% to 97.6%</td>
<td>53.4</td>
</tr>
<tr>
<td>Random-Effects Model</td>
<td>Trials</td>
<td>N</td>
<td>Outcomes</td>
<td>Effect Size</td>
<td>95% CI</td>
<td>P₁, %</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>-----</td>
<td>----------------------------------------------------</td>
<td>-------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>For ≥6 mm polyps</td>
<td>7</td>
<td>NR</td>
<td>Diagnostic accuracy for ≥6 mm polyps using 1st-generation CCE</td>
<td>NLR=0.22</td>
<td>0.13 to 0.34</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DOR=90.4</td>
<td>44 to 163</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sens=58%</td>
<td>44% to 70%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spec =85.7%</td>
<td>80.2% to 90.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PLR=3.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NLR=0.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DOR=7.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For ≥6 mm polyps</td>
<td>6</td>
<td>NR</td>
<td>Diagnostic accuracy for ≥6 mm polyps using 2nd-generation CCE</td>
<td>Sens=86%</td>
<td>82% to 89%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spec =88.1%</td>
<td>74.2% to 95.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PLR=7.9</td>
<td>3.7 to 16.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NLR=0.16</td>
<td>0.12 to 0.21</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DOR=50.5</td>
<td>20.3 to 107.0</td>
<td></td>
</tr>
<tr>
<td>For ≥10 mm polyps</td>
<td>3</td>
<td>NR</td>
<td>Diagnostic accuracy for ≥10 mm polyps using 1st-generation CCE</td>
<td>Sens=54%</td>
<td>29% to 77%</td>
<td>76.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spec =97.4%</td>
<td>96.0% to 98.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PLR=NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NLR=NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DOR=NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For ≥10 mm polyps</td>
<td>6</td>
<td>NR</td>
<td>Diagnostic accuracy for ≥10 mm polyps using 2nd-generation CCE</td>
<td>Sens=88%</td>
<td>81% to 91%</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spec =95.3%</td>
<td>91.5% to 97.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PLR=NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NLR=NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DOR=NR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Kjolhede et al (2020)²⁴**

| For polyps of any size | 4      | 338 | Diagnostic accuracy for polyps of any size | Sens=85%    | 73% to 92%    | NR    |
|                       |        |     |                                              | Spec =85%   | 70% to 93%    |       |
|                       |        |     |                                              | PLR=NR      |               |       |
|                       |        |     |                                              | NLR=NR      |               |       |
|                       |        |     |                                              | DOR=30.5    | 16.2 to 57.2  |       |
| For polyps ≥ 6 mm     | 6      | 1324| Diagnostic accuracy for polyps ≥ 6 mm        | Sens=87%    | 83% to 90%    | NR    |
|                       |        |     |                                              | Spec =88%   | 75% to 95%    |       |
|                       |        |     |                                              | PLR=NR      |               |       |
|                       |        |     |                                              | NLR=NR      |               |       |
|                       |        |     |                                              | DOR=51.1    | 19.8 to 131.8 |       |
| For polyps ≥ 10 mm    | 7      | 1577| Diagnostic accuracy for polyps ≥ 10 mm       | Sens=87%    | 82% to 90%    | NR    |
|                       |        |     |                                              | Spec =95%   | 92% to 97%    |       |
|                       |        |     |                                              | PLR=NR      |               |       |
|                       |        |     |                                              | NLR=NR      |               |       |
|                       |        |     |                                              | DOR=136.0   | 70.6 to 262.1 |       |

CCE: colon capsule endoscopy; CI: confidence interval; DOR: diagnostic odds ratio; NLR: negative likelihood ratio; NR: not reported; PLR: positive likelihood ratio; Sens: sensitivity; Spec: specificity.

**Prospective Studies**

Other recent studies by Saito et al (2015), Morgan et al (2016), and Parodi (2018) have evaluated the diagnostic characteristics of CCE, using subsequently performed colonoscopy as the reference standard.²⁵,³⁶,³⁷ In the Saito et al (2015) study, of 66 evaluable patients, per-patient sensitivity for the detection of polyps was 94% (95% CI, 88.2% to 99.7%). In the Morgan et al (2016) study, for lesions 10 mm or larger, sensitivity of CE was 100% (95% CI, 56.1% to 100%), with a specificity of 93.0% (95% CI, 79.9% to 98.2%). For lesions 6 mm or larger, sensitivity was 93.3% (95% CI, 66.0% to 99.7%) and the specificity was 80.0% (95% CI, 62.5% to 90.9%). The Parodi (2018) study included 177 first-degree relatives of individuals with colorectal cancer and found, for lesions 6 mm or larger, a sensitivity of 91% (95% CI, 81% to 96%) and a specificity of 88% (95% CI, 81% to 93%).³⁷

**Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive
Correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for diagnosing colon cancer has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

**Section Summary: Colon Cancer Screening**
Studies of diagnostic characteristics alone are insufficient evidence to determine the efficacy of CE for colon cancer screening. Because diagnostic performance is worse than standard colonoscopy, CE would need to be performed more frequently than standard colonoscopy to have comparable efficacy. Without direct evidence of efficacy in a clinical trial of colon cancer screening using CE, modeling studies using established mathematical models of colon precursor incidence and progression to cancer could provide estimates of efficacy in preventing colon cancer mortality. Studies of CE in screening populations are necessary to determine the diagnostic characteristics of the test in this setting.

**Lower GI Tract Bleeding and Major Risks for Colonoscopy or Moderate Sedation**

**Clinical Context and Test Purpose**
The purpose of wireless CE for patients with evidence of gastrointestinal bleeding of lower GI origin and major risks for colonoscopy or moderate sedation is to visualize the colon for the detection of polyps or other sources of lower GI bleeding and inform a decision to proceed to further treatment and testing.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with evidence of gastrointestinal bleeding of lower GI origin and major risks for colonoscopy or moderate sedation?

The following PICO was used to select literature to inform this review.

**Populations**
The relevant population of interest is patients with evidence of gastrointestinal bleeding of lower GI origin and major risks for colonoscopy or moderate sedation, but who could tolerate colonoscopy and moderate sedation in the event a clinically significant colon abnormality was identified with wireless CE.

**Interventions**
The intervention of interest is wireless CE for the visualization of the colon and detection of polyps or other sources of lower GI bleeding, which is performed by gastroenterologists in an outpatient setting. Symptomatic patients assessed for colorectal polyps may be actively managed by gastroenterologists, radiologists, surgeons, and primary care providers in an outpatient setting.

**Comparators**
The following reference standard is currently being used to detect colon polyps: standard workup using optical colonoscopy, which is performed by gastroenterologists in an outpatient setting.
setting. Symptomatic patients assessed for colorectal polyps may be actively managed by gastroenterologists and primary care providers in an outpatient setting.

**Outcomes**

The outcomes of interest for diagnostic accuracy include test validity. The primary outcomes of interest are symptoms, disease status, and resource utilization that would change due to patient management decisions following wireless CE.

Beneficial outcomes resulting from a true-negative test result are avoiding unnecessary subsequent testing. Harmful outcomes resulting from a false-positive test result are unnecessary testing or therapeutic intervention. Harmful outcomes resulting from a false-negative test result are increased risk of further disease progression and missed colorectal disease.

Therefore, in the evaluation of wireless CE as a triage test, the test would need to identify precisely a group of patients that could safely forgo additional testing; therefore, the sensitivity, specificity, negative predictive value and negative likelihood ratio are key test validity characteristics.

**Technically Reliable**

Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

**Study Selection Criteria**

Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-negative results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

**Diagnostic Accuracy Studies**

Several studies have evaluated the diagnostic characteristics of CE for the detection of colon polyps in patients with evidence of lower GI bleeding (e.g., hematochezia, positive fecal occult blood test [FOBT]). Study characteristics and results are described in Table 22 and 23.

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Reference Standard</th>
<th>Threshold for Positive Index Test</th>
<th>Timing of Reference and Index Tests</th>
<th>Blinding of Assessors</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kobaek-Larsen et al (2017)</td>
<td>FOBT-positive individuals participating in a CRC screening program in Denmark (N=253; OC adjusted by any findings from all follow-up procedures; repeat colonoscopy)</td>
<td>OC adjusted by any findings from all follow-up procedures; repeat colonoscopy</td>
<td>Polyps &gt;9 mm within ±50% of CE measure</td>
<td>OC performed 1 day after CE</td>
<td>Investigators were blinded to both CE and OC; in the case of a second RS adjusted in 75 patients due to follow-up procedures only 50% (126)</td>
<td></td>
</tr>
</tbody>
</table>
### Table 23. Study Results of Clinical Validity

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Reference Standard</th>
<th>Threshold for Positive Index Test</th>
<th>Timing of Reference and Index Tests</th>
<th>Blinding of Assessors</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kobaek-Larsen et al (2017)</td>
<td>Individuals with known or suspected colonic disease in Israel (N=104; mean age, 49.8)</td>
<td>OC</td>
<td>Polyps ≥6 mm and ≥10 mm within +50% of CE measure</td>
<td>OC performed within 10 hours of CE</td>
<td>Investigators blinded to both OC and CE</td>
<td>None related to OC or CE.</td>
</tr>
<tr>
<td></td>
<td>All patients; CE &gt;9 mm</td>
<td>253</td>
<td>54 (48 to 60)</td>
<td>87 (83 to 91)</td>
<td>92 (89 to 95)</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td>Complete CE and OC; CE &gt;9 mm</td>
<td>126</td>
<td>---</td>
<td>97 (94 to 100)</td>
<td>90 (85 to 95)</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td>All patients; OC &gt;9 mm</td>
<td>253</td>
<td>90 (86 to 94)</td>
<td>88 (84 to 92)</td>
<td>100 (100)</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td>Complete CE and OC; OC &gt;9 mm</td>
<td>126</td>
<td>---</td>
<td>89 (84 to 94)</td>
<td>100 (100)</td>
<td>NR</td>
</tr>
<tr>
<td>Rondonotti et al (2014)</td>
<td>FOBT-positive individuals participating in a CRC screening program in Italy (N=54; age range, 50-69)</td>
<td>OC followed by colon segment re-inspection if double unblinding to CTC and CE results revealed a disparity</td>
<td>Polyps ≥6 mm</td>
<td>CTC and OC performed 15 days after CE</td>
<td>Initial blinding to CE and CTC followed by double-unblinding and opportunity for re-inspection and adjustment of RS</td>
<td>4 patients excluded from analysis (consent withdrawal [2], endoscopist not blinded [2])</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>100</td>
<td>88.2 (62.2 to 97.9)</td>
<td>87.8 (70.8 to 96.0)</td>
<td>3.75; 0.06</td>
<td>None related to OC or C. 10 cases of mild abdominal pain and 2 cases of significant pain during CTC.</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>100</td>
<td>88.2 (62.2 to 97.9)</td>
<td>84.8 (67.3 to 94.3)</td>
<td>3.0; 0.07</td>
<td>1 capsule retention; 7 cases</td>
</tr>
</tbody>
</table>

Kobaek-Larsen et al (2017) reported on FOBT-positive individuals participating in a colorectal cancer screening program in Denmark.38, The reference standard consisted of OC adjusted by any findings from all additional follow-up procedures, including repeat endoscopy due to suspected missed polyps unblinded to CE results in 53 patients, repeated OC due to inadequate bowel preparation in 8 patients, and follow-up CT colonography in 14 patients. CE completion rate was significantly lower than OC (P < 0.001), with only 50% of patients (n = 126) having complete OC and CE investigations.

Rondonotti et al (2014) reported on FOBT-positive individuals participating in a colorectal cancer screening program in Italy.39, Unblinded colonoscopy, integrating OC, CTC, and CE results, was used as the reference standard. Investigations were completed in all patients with a PLR and NLR of 3.75 and 0.06 for CE, respectively.

Eliakim et al (2009) conducted a prospective, multicenter study evaluating CE compared to colonoscopy in individuals with known or suspected colonic disease.40, Twenty-one percent of patients had hematochezia or positive FOBT. The majority of patients were referred for OC due to personal or family history of colorectal cancer or for colorectal cancer screening. Polyps of any size were detected in 44% of patients, with 53% identified as having adenomas. Overall colon cleanliness for CE was considered adequate in 78% of patients (95% CI, 68 to 86%).

Study relevance, design, and conduct limitations are described in Table 24 and 25.

**Table 24. Study Relevance Limitations**

<table>
<thead>
<tr>
<th>Study</th>
<th>Populationa</th>
<th>Interventionb</th>
<th>Comparatorc</th>
<th>Outcomesd</th>
<th>Duration of Follow-Upæ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kobaek-Larsen et al (2017)38</td>
<td>1. Study did not specifically evaluate individuals with major risks for colonoscopy or moderate sedation.</td>
<td>2. Adjusted and/or unblinded reference standard not uniformly applied to all patients.</td>
<td>1.3. Impact of findings on health outcomes not assessed. Predictive values not reported.</td>
<td>4. Study did not specifically evaluate individuals with major risks for colonoscopy or moderate sedation.</td>
<td>4. Study did not specifically evaluate individuals with major risks for colonoscopy or moderate sedation.</td>
</tr>
<tr>
<td>Rondonotti et al (2014)39</td>
<td>4. Study did not specifically evaluate individuals with major risks for colonoscopy or moderate sedation.</td>
<td>1. Impact of findings on health outcomes not assessed.</td>
<td>4. Study did not specifically evaluate</td>
<td>4. Study did not specifically evaluate</td>
<td></td>
</tr>
</tbody>
</table>
Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<table>
<thead>
<tr>
<th>Study</th>
<th>Populationa</th>
<th>Interventionb</th>
<th>Comparator</th>
<th>Outcomesd</th>
<th>Duration of Follow-Upé</th>
</tr>
</thead>
<tbody>
<tr>
<td>individuals with major risks for colonoscopy or moderate sedation; only 21% of subjects had evidence of lower gastrointestinal bleeding.</td>
<td>outcomes not assessed. Predictive values not reported.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 25. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Selectiona</th>
<th>Blindingb</th>
<th>Delivery of Testc</th>
<th>Selective Reportingd</th>
<th>Data Completenessé</th>
<th>Statisticalf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kobaek-Larsen et al (2017)²⁸</td>
<td>1. Selection not described.</td>
<td>1. In case of second endoscopy for suspected missed polyps, endoscopist not blinded to results of CE.</td>
<td></td>
<td></td>
<td>1,3. Unclear how many complete investigations included patients with comparison to adjusted and/or unblinded reference standard. High loss due to low CE completion rate.</td>
<td></td>
</tr>
<tr>
<td>Rondonotti et al (2014)³⁹</td>
<td>1. Selection not described.</td>
<td>1. Endoscopist was unblinded to results of CE and CTC in event polyps were missed prior to segment reinspection.</td>
<td>2. CTC and OC performed 15 days later.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; CTC: computed tomography colonography; OC: optical colonoscopy.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<table>
<thead>
<tr>
<th>Study</th>
<th>Selectiona</th>
<th>Blindingb</th>
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<td></td>
<td></td>
<td>1,3. Unclear how many complete investigations included patients with comparison to adjusted and/or unblinded reference standard. High loss due to low CE completion rate.</td>
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Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of wireless CE for detecting colon polyps in this population has not been established, a chain of evidence supporting the test's clinical utility for this indication cannot be constructed.

Section Summary: Lower GI Tract Bleeding and Major Risks for Colonoscopy or Moderate Sedation
Studies evaluating the diagnostic characteristics of CE as a triage test have primarily involved colorectal cancer screening populations that have not specifically enrolled patients with major risks for OC or moderate sedation. The 3 studies identified have been heterogeneous in the timing of delivery of the reference standard, in the definition and blinding of the reference standard, and in the significant polyp size threshold determining a positive test result. Only 1 small study reported positive and negative likelihood ratios. Per-patient sensitivity and specificity ranged from 88 to 97% and 76 to 92% respectively, and was generally reported with wide confidence intervals. While 1 study reported a higher sensitivity and specificity compared to OC versus the defined reference standard, a consistent reference standard was not applied to all patients and carried a low combined rate of complete OC and CE investigations (50%). No studies assessed the impact of study findings on specific health outcomes. Adherence to recommended follow-up diagnostic or therapeutic interventions in patients with major risks for colonoscopy or moderate sedation is unknown. Studies of CE in the intended use population are necessary to determine the diagnostic characteristics of the test in the triage setting.

Incomplete Colonoscopy
Clinical Context and Test Purpose
The purpose of wireless CE for patients with an incomplete colonoscopy after adequate preparation where a complete evaluation of the colon was not technically possible is to visualize the colon for the detection of polyps and inform a decision to proceed to further treatment and testing.

The question addressed in this evidence review is: Does the use of wireless CE improve the net health outcome in patients with an incomplete colonoscopy after adequate preparation where a complete evaluation of the colon was not technically possible?

The following PICO was used to select literature to inform this review.
Populations
The relevant population of interest is patients undergoing screening for colon polyps who experience an incomplete colonoscopy after adequate bowel preparation where a complete visualization of the colon was not technically possible. Factors that may contribute to incomplete colonoscopies include patient pain and discomfort, diverticulosis, tortuosity, adhesions due to prior surgeries, angulation or fixation of bowel loops, ineffective sedation, and endoscopist and technician expertise.

Interventions
The intervention of interest is wireless CE for the detection of colon polyps, which is performed by gastroenterologists in an outpatient setting. Patients assessed for colon polyps are actively managed by gastroenterologists, radiologists, surgeons, and primary care providers in an outpatient setting.

Comparators
The comparator of interest is repeat optical colonoscopy. Repeat colonoscopy following a prior incomplete procedure may be modified with adjusted endoscopic techniques, pediatric instruments, abdominal pressure and position changes, water exchange and water immersion techniques, carbon dioxide insufflation, magnetic endoscope imaging, alternate sedation methods, anesthesia assistance, and management with more experienced physicians.

Outcomes
The outcomes of interest for diagnostic accuracy include test validity. The primary outcomes of interest are symptoms, disease status, and resource utilization that would change due to patient management decisions following wireless CE.

Beneficial outcomes resulting from a true-negative test result are avoiding unnecessary repeat colonoscopy. Harmful outcomes resulting from a false-positive test result are unnecessary testing or therapeutic intervention. Harmful outcomes resulting from a false-negative test result are increased risk of missed colorectal disease.

Therefore, in the evaluation of wireless CE as a triage test, the test would need to identify precisely a group of patients that could safely forgo additional testing; therefore, the sensitivity, specificity, negative predictive value, and negative likelihood ratio are key test validity characteristics.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-negative results are ideal. Studies reporting other measures (e.g.,

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receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.

- Studies should also report reclassification of the diagnostic or risk category.

**Case Series**

Studies evaluating the diagnostic characteristics of CE compared to a reference standard for the detection of colon polyps in patients with an incomplete colonoscopy following adequate bowel preparation were not identified. Several prospective case series describing the diagnostic yield of CE following incomplete colonoscopy for various indications are summarized in Table 26. Study relevance, design, and conduct limitations are described in Table 27 and 28.

**Table 26. Study Characteristics and Results**

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Indications for OC</th>
<th>Threshold for Significant Polyps</th>
<th>Timing of CE</th>
<th>Incremental CE Diagnostic Yield, n/N (%)</th>
<th>Complete Visualization of the Colon, n/N (%)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hussey et al (2018)</td>
<td>Patients aged ≥18 y who had an incomplete OC for reasons other than poor bowel preparation or suspected obstruction of the colonic lumen (N=50)</td>
<td>NR</td>
<td>&gt;6mm or ≥ 3 polyps</td>
<td>Administered 90 min after IC</td>
<td>CE (any polyps): 19/50 (38)</td>
<td>CE: 38/50 (76)</td>
<td>CCE Findings (n): normal (13), polyps (19; 7/19 significant), inflammation (1), diverticular disease (1), angiodysplasia (1), cancer (1). 7 patients with significant polyps were referred for polypectomy which detected 14 adenomas and hyperplastic polyps.</td>
</tr>
<tr>
<td>Baltes et al (2018)</td>
<td>Patients aged ≥18 y who had an incomplete OC due to failure to reach the cecum or ileo-cecal anastomosis due to looping, bowel angulation, adhesions, and intolerance of sedation or inflammation (N=81)</td>
<td>CRC screening (22%), anemia (15%), hematochezia (15%), irregular stool (12%), abdominal pain (12%), B symptoms (7%), colitis (5%), other reasons (12%)</td>
<td>≥6mm or ≥ 3 polyps</td>
<td>Protocol A: next day CE (n=38)</td>
<td>CE (significant polyps): NR (24)</td>
<td>Protocol A: CE: 24/38 (63.3) CE + IC: 34/38 (89.5)</td>
<td>Per protocol analysis: 74/81 due to 7 exclusions for technical failure</td>
</tr>
<tr>
<td>Nogales et al (2017)</td>
<td>Patients aged ≥18 y who had an incomplete OC when cecal intubation was not achieved despite adequate bowel preparation (N=96)</td>
<td>NR</td>
<td>&gt;6mm or ≥ 3 polyps</td>
<td>Within 72 hours in 8 cases of suspected CRC. During the following week for all other patients.</td>
<td>CE (any diagnosis): 58/96 (60.4)</td>
<td>CE + IC: 89/96 (92.7)</td>
<td>CCE Findings (n): polyps (41; 25/41 significant), diverticula (11), colon cancer (2), angiodysplasia (2), solitary colonic ulcers (2). In 43/58 patients (44.8%) the new findings modified the therapeutic approach.</td>
</tr>
<tr>
<td>Negreanu et al (2013)</td>
<td>Patients who are risk for CRC who 1) refused (n=37) or failed prior OC (n=30), or 2) unable to undergo OC because of anesthetic risk and co-morbidities (n=3) (N=70)</td>
<td>Abnormal transit (8), abdominal pain (4), anemia or overt bleeding (22), weight loss (1), average and high risk CRC screening (29), abnormal imaging or tumor markers (6)</td>
<td>&gt;6 mm or ≥ 3 polyps</td>
<td>NR</td>
<td>CE (relevant lesions): 23/67 (34) [95% CI, 21.6 to 44.1]</td>
<td>CE: 51/67 (76.1)</td>
<td>Exclusions: technical failures (3)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Patients with an indication for OC per the recommendations of the French National Authority for Health, including symptoms or screening who had 1) colonoscopy failure due to difficult sigmoid loop or adhesions not related to stenosis or inadequate bowel cleansing (n=77) or 2) contraindication to OC with anesthesia due to cardiovascular or respiratory disease (n=30) (N=107)</td>
<td>Abnormal transit (14), abdominal pain (22), anemia or overt bleeding (30), weight loss (2), CRC screening (39)</td>
<td>&gt;5 mm or ≥ 3 polyps</td>
<td>NR</td>
<td>CE (significant polyps, screening): 12/39 (30.8) [95% CI, 22.1 to 39.5]</td>
<td>CE: 89/107 (83.2) [95% CI, 76.1 to 90.3]</td>
<td>CCE Findings (n): polyps &gt;6 mm (5), ≥ 3 polyps (10), multiple colonic angiomas (2), newly discovered Crohn disease (1), radiation enteritis (1), diverticulosis (17), ulcerative colitis and inflammatory pseudopolyps (1), &lt;6 mm polyp (1).</td>
</tr>
</tbody>
</table>

17/23 patients with relevant lesions agreed to therapeutic interventions. 1 clinical failure (ulcerated rectal tumor) who refused OC following incomplete CE was reported.

Adverse events: capsule impaction and retention (5)
Table 27. Study Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
<th>Duration of Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltes et al (2018)</td>
<td>1. It is not clear whether detection of polyps was the primary goal of CE for symptomatic patients.</td>
<td>2. Not compared to a reference standard.</td>
<td>1,3. Impact of findings on health outcomes not assessed. Clinical validity outcomes cannot be assessed.</td>
<td>1. No follow-up with reference standard.</td>
<td></td>
</tr>
<tr>
<td>Negreanu et al (2013)</td>
<td>1,4. It is not clear whether detection of polyps was the primary goal of CE for symptomatic patients. Only a small subset of study patients reported IC.</td>
<td>2. Not compared to a reference standard.</td>
<td>1,3. Impact of findings on health outcomes not assessed. Clinical validity outcomes cannot be assessed.</td>
<td>1. No follow-up with reference standard.</td>
<td></td>
</tr>
<tr>
<td>Pioche et al (2012)</td>
<td>1,4. It is not clear whether detection of polyps was the primary goal of CE for symptomatic patients. Only a subset of study patients reported IC.</td>
<td>2. Not compared to a reference standard.</td>
<td>1,3. Impact of findings on health outcomes not assessed. Clinical validity outcomes cannot be assessed.</td>
<td>1. No follow-up with reference standard.</td>
<td></td>
</tr>
</tbody>
</table>

CE: capsule endoscopy; IC: incomplete colonoscopy; OC: optical colonoscopy.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

- Population: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
- Comparator: 1. Classification thresholds not defined; 2. Not compared to credible reference standard; 3. Not compared to other tests in use for same purpose.
- Outcomes: 1. Study does not directly assess a key health outcome; 2. Evidence chain or decision model not explicated; 3. Key clinical validity outcomes not reported (sensitivity, specificity and predictive values); 4. Reclassification of diagnostic or risk categories not reported; 5. Adverse events of the test not described (excluding minor discomforts and inconvenience of venipuncture or noninvasive tests).
Table 28. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Selectiona</th>
<th>Blindingb</th>
<th>Delivery of Testc</th>
<th>Selective Reportingd</th>
<th>Data Completenessa</th>
<th>Statisticalf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nogales et al (2017)46</td>
<td>1. No comparison to reference standard.</td>
<td>1. Not registered.</td>
<td>2. Comparison to other tests not reported.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CE: capsule endoscopy.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

a Selection key: 1. Selection not described; 2. Selection not random or consecutive (i.e., convenience).
b Blinding key: 1. Not blinded to results of reference or other comparator tests.
c Test Delivery key: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.
e Data Completeness key: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to follow-up or missing data.
f Statistical key: 1. Confidence intervals and/or p values not reported; 2. Comparison to other tests not reported.

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

**Chain of Evidence**
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.
Because the clinical validity of wireless CE for detecting colon polyps in this population has not been established, a chain of evidence supporting the test’s clinical utility for this indication cannot be constructed.

Section Summary: Incomplete Colonoscopy
No studies evaluating the diagnostic characteristics of CE compared to a reference standard for the detection of colon polyps in patients with an incomplete colonoscopy following adequate bowel preparation were identified. Case series describing the incremental diagnostic yield of CE varied in their reporting of original indications for OC and inclusion of symptomatic and/or screening patients. It is unclear whether the primary goal of CE was the detection of colon polyps in symptomatic patients, as these lesions were reported as not explaining symptoms in 1 study. Successful CE completion rates were low (range, 63.3 to 83.2%) with 3/5 studies reporting full visualization of the colon for combined CE and IC in 84 to 97.2% of patients. Given the variable prevalence of significant and actionable findings for patients with mixed indications for colonoscopy, the diagnostic yield is insufficient to determine the clinical validity of the test. No studies assessed the impact of study findings on specific health outcomes.

Information on adherence to recommended follow-up diagnostic or therapeutic interventions in patients with incomplete colonoscopies are limited, with several refusals and clinical failures reported. Studies of CE compared to standard management with repeat colonoscopy in the intended use population are necessary to determine the diagnostic characteristics of the test in the triage setting.

Known or Suspected Small Bowel Stricture
Clinical Context and Test Purpose
The purpose of the patency capsule for patients scheduled to undergo CE for known or suspected small bowel stricture is to confirm a diagnosis and inform a decision to proceed to CE.

The question addressed in this evidence review is: Does the use of a patency capsule improve the net health outcome in patients with known or suspected small bowel stricture?

The following PICO was used to select literature to inform this review.

Populations
The relevant population of interest is individuals scheduled to undergo CE for known or suspected small bowel stricture. Contraindications to the use of CE include known or suspected obstruction or stricture, Zenker diverticulum, intestinal pseudo-obstruction, and motility disorders. Certain patients with known or suspected strictures of the small bowel may be at risk of retaining the capsule. Surgical removal may be necessary.

Interventions
The test being considered is a patency capsule as a technique to evaluate patients with known or suspected strictures before using wireless CE. The capsule could be to select patients for CE instead of assessing clinical risk factors.

The use of the patency capsule has some risk itself. Published studies are small and do not provide comparative data on the incremental value of this capsule over standard clinical evaluation. In some series, the administration of the patency capsule has produced symptoms requiring hospitalization and even surgery. In a European study, Spada et al (2007) reported findings for 27 patients, 24 with CD. In this study, 25 (92.6%) patients retrieved the patency capsule in their stools. Six patients complained of abdominal pain, 4 of whom excreted a nonintact capsule, and hospitalization was required in 1 patient due to the occlusive syndrome.

Patients who are scheduled to undergo patency capsule screening before wireless CE for known or suspected small bowel stricture are actively managed by oncologists, gastroenterologists, radiologists, surgeons, and primary care providers in an outpatient clinical setting.
Comparators
The following practices are currently being used to diagnose known or suspected small bowel stricture: CE without patency capsule and alternative workup without CE, which is performed in an outpatient setting. Patients are actively managed by oncologists, gastroenterologists, radiologists, surgeons, and primary care providers in an outpatient clinical setting.

Outcomes
The general outcomes of interest are test validity, symptoms, change in disease status, and treatment-related morbidity.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Study Selection Criteria
Below are selection criteria for studies to assess whether a test is clinically valid. These will be applied to all of the indications reviewed in this policy.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operator curve, area under the receiver operator curve, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of the diagnostic or risk category.

In a series from Europe, Delvaux et al (2005) reported on findings in 22 patients with suspected intestinal stricture, 15 of whom had CD. In this study, at 30 hours after ingestion, the patency capsule was detected in 17 (72.3%) patients. In all patients in whom the capsule was blocked in the small intestine, the stenosis had been suspected on CT scan or small bowel follow-through. In 3 patients, the delay in the progression of the patency capsule led to the cancellation of CE. In 3 patients, the patency capsule induced a symptomatic intestinal occlusion, which resolved spontaneously in 1 and required emergency surgery in 2. The authors commented that the current technical development of the patency capsule limits its use in clinical practice, because it did not detect stenoses undiagnosed by CT or small bowel follow-through, and the start of dissolution at 40 hours after ingestion is too slow to prevent episodes of intestinal occlusion. They also commented that a careful interview eliciting the patient's history and symptoms remains the most useful indicator for suspicion of an intestinal stenosis.

Several studies have shown that patients who had an uncomplicated passage of the patency capsule subsequently underwent uncomplicated CE. These patients often had significant findings on CE. However, it is difficult to determine whether CE findings in these patients improved their outcomes beyond any alternative testing regimen available. In 1 of these studies, 3 of 106 patients had severe adverse events, including 1 patient who required surgery.
Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs assessing the clinical utility of wireless CE for this indication were identified.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of the patency capsule for diagnosing known or suspected strictures has not been established, a chain of evidence supporting the test's clinical utility for this indication cannot be constructed.

Section Summary: Bowel Stricture
The overall balance of harm and benefit of using the patency capsule cannot be determined from the existing studies.

Summary of Evidence
Patients With Suspected GI Disorders
For individuals who have suspected small bowel bleeding (previously referred to as obscure GI bleeding) who receive wireless CE, the evidence includes numerous case series evaluating patients with a nondiagnostic standard workup. Relevant outcomes are test validity, other test performance measures, symptoms, and change in disease status. The evidence has demonstrated that CE can identify a bleeding source in a substantial number of patients who cannot be diagnosed by other methods, with a low incidence of adverse events. Because there are few other options for diagnosing obscure small bowel bleeding in patients with negative upper and lower endoscopy, this technique will likely improve health outcomes by directing specific treatment when a bleeding source is identified. The evidence is sufficient to determine that the technology results in an improvement in the net health outcomes.

For individuals who have suspected Crohn disease (CD) who receive wireless CE, the evidence includes case series. Relevant outcomes are test validity, other test performance measures, symptoms, and change in disease status. Although the test performance characteristics and diagnostic yields of the capsule for this indication are uncertain, the diagnostic yields are as good as or better than other diagnostic options, and these data are likely to improve health outcomes by identifying some cases of CD and directing specific treatment. The evidence is sufficient to determine that the technology results in an improvement in the net health outcomes.

For individuals who have suspected celiac disease who receive wireless CE, the evidence includes case series and diagnostic accuracy studies. Relevant outcomes are test validity, other test performance measures, symptoms, and change in disease status. The diagnostic characteristics of CE are inadequate to substitute for other modalities or to triage patients to other modalities. For other conditions (e.g., determining the extent of CD), direct evidence of improved outcomes or a strong indirect chain of evidence to improved outcomes is lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.
For individuals who have unexplained chronic abdominal pain who receive wireless CE, the evidence includes case series and diagnostic accuracy studies. Relevant outcomes are test validity, other test performance measures, symptoms, and change in disease status. The diagnostic characteristics of CE are inadequate to substitute for other modalities or to triage patients to other modalities. For other conditions (e.g., determining the extent of CD), direct evidence of improved outcomes or a strong chain of evidence to improved outcomes is lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Patients With Confirmed GI Disorders
For individuals who have an established diagnosis of CD who receive wireless CE, the evidence includes diagnostic accuracy studies and a systematic review. Relevant outcomes are test validity, other test performance measures, symptoms, and change in disease status. A 2017 systematic review of 11 studies in patients with established CD found a similar diagnostic yield with CE and with radiography. Because there is evidence that the diagnostic yields are as good as or better than other diagnostic options, there is indirect evidence that CE is likely to improve health outcomes by identifying some cases of CD and directing specific treatment. The evidence is sufficient to determine that the technology results in an improvement in the net health outcomes.

For individuals who have ulcerative colitis who receive wireless CE, the evidence includes case series and diagnostic accuracy studies. Several diagnostic accuracy studies have compared CE with colonoscopy to assess disease activity in patients with ulcerative colitis. Two of 3 studies were small (i.e., <50 patients) and thus data on diagnostic accuracy are limited. Direct evidence of improved outcomes and a strong chain of evidence to improved outcomes are lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

For individuals who have esophageal disorders who receive wireless CE, the evidence includes case series and diagnostic accuracy studies. Other available modalities are superior to CE. The diagnostic characteristics of CE are inadequate to substitute for other modalities or to triage patients to other modalities. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

For individuals who have hereditary GI polyposis syndromes who receive wireless CE, the evidence includes case series and diagnostic accuracy studies. The data are insufficient to determine whether evaluation with CE would improve patient outcomes. Further information on the prevalence and natural history of small bowel polyps in Lynch syndrome patients is necessary. At present, surveillance of the small bowel is not generally recommended as a routine intervention for patients with Lynch syndrome. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

For individuals who have portal hypertensive enteropathy who receive wireless CE, the evidence includes case series and diagnostic accuracy studies. Systematic reviews of studies of CE's diagnostic performance for this indicated have reported limited sensitivity and specificity. Due to insufficient data on diagnostic accuracy, a chain of evidence on clinical utility cannot be constructed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.
Acute Upper GI Bleeding
For individuals who have acute upper GI tract bleeding who receive wireless CE, the evidence includes an RCT and several cohort studies. Relevant outcomes are test validity, and other test performance measures, symptoms, hospitalizations, and resource utilization. The use of CE in the emergency department setting for suspected upper GI bleeding is intended to avoid unnecessary hospitalization or immediate endoscopy. Controlled studies are needed to assess further the impact of CE on health outcomes compared with standard management. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Colon Cancer Screening
For individuals who are screened for colon cancer who receive wireless CE, the evidence includes diagnostic accuracy studies and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, test validity, and other test performance measures. Studies of CE in screening populations are necessary to determine the diagnostic characteristics of the test in this setting. Studies of diagnostic characteristics alone are insufficient evidence to determine the efficacy of CE for colon cancer screening. Because diagnostic performance is worse than standard colonoscopy, CE would need to be performed more frequently than standard colonoscopy to have comparable efficacy. Without direct evidence of efficacy in a clinical trial of colon cancer screening using CE, modeling studies using established mathematical models of colon precursor incidence and progression to cancer could provide estimates of efficacy in preventing colon cancer mortality. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Lower GI Tract Bleeding and Major Risks for Colonoscopy or Moderate Sedation
For individuals who are screened for colon polyps with evidence of lower GI tract bleeding and major risks for colonoscopy or moderate sedation who receive wireless CE, the evidence includes diagnostic accuracy studies. Relevant outcomes are overall survival, disease-specific survival, resource utilization, test validity, and other test performance measures. Studies of CE in the intended use population are necessary to determine the diagnostic characteristics of the test in the triage setting. Studies of diagnostic characteristics alone are insufficient evidence to determine the clinical utility of CE in this population, and no studies adequately assess the impact of findings on specific health outcomes or patient adherence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Incomplete Colonoscopy
For individuals who are screened for colon polyps following an incomplete colonoscopy with adequate preparation who receive wireless CE, the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, resource utilization, test validity, and other test performance measures. Studies of CE compared to standard management with repeat colonoscopy in the intended use population are necessary to determine the diagnostic characteristics of the test in the triage setting. Studies of diagnostic characteristics alone are insufficient evidence to determine the clinical utility of CE in this population, and no studies adequately assess the impact of findings on specific health outcomes or patient adherence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Patency Capsule for Patients with Bowel Stricture
For individuals who are scheduled to undergo CE for known or suspected small bowel stricture who receive a patency capsule, the evidence includes case series. Relevant outcomes are test validity, symptoms, change in disease status, and treatment-related morbidity. The available studies have reported that CE following a successful patency capsule test results in high rates of success with low rates of adverse events. The capsule is also associated with adverse events. Because of the lack of comparative data to other diagnostic strategies, it is not possible to determine whether the use of the patency capsule improves the net health outcome. The
evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

American College of Gastroenterology
In 2013, the American College of Gastroenterology (ACG) issued guidelines on the diagnosis and management of celiac disease. The guidelines recommended that capsule endoscopy (CE) not be used for initial diagnosis, except for patients with positive celiac-specific serology who are unwilling or unable to undergo upper endoscopy with biopsy (strong recommendation, moderate level of evidence).

CE should be considered for the evaluation of small bowel mucosa in patients with complicated Crohn disease (CD; strong recommendation, moderate level of evidence).

In 2018, the ACG updated its guidelines on the management of CD in adults. It makes 2 recommendations specific to video capsule endoscopy:

“Video capsule endoscopy (VCE) is a useful adjunct in the diagnosis of patients with small bowel Crohn’s disease in patients in whom there is a high index of suspicion of disease.”

“Patients with obstructive symptoms should have small bowel imaging and/or patency capsule evaluation before VCE to decrease risk of capsule retention.”

These recommendations are based on multiple studies. Capsule endoscopy was found to be “superior to small bowel barium studies, computed tomography enterography (CTE) and ileocolonoscopy in patients with suspected CD, with incremental yield of diagnosis of 32%, 47% and 22% respectively….Capsule endoscopy has a high negative predictive value of 96%.”

“However, some studies have questioned the specificity of capsule endoscopy findings for CD, and to date there is no consensus as to exactly which capsule endoscopy findings constitute a diagnosis of CD.”

In 2015, the ACG issued guidelines on the diagnosis and management of small bowel bleeding (including using “small bowel bleeding” to replace “obscure GI [gastrointestinal] bleeding,” which should be reserved for patients in whom a source of bleeding cannot be identified anywhere in the GI tract). These guidelines made the following statements related to video CE (see Table 29).

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>SOR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“… VCE should be considered as a first-line procedure for SB evaluation after upper and lower GI sources have been excluded, including second-look endoscopy when indicated”</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>“VCE should be performed before deep enteroscopy to increase diagnostic yield. Initial deep enteroscopy can be considered in cases of massive hemorrhage or when VCE is contraindicated”</td>
<td>Strong</td>
<td>High</td>
</tr>
</tbody>
</table>

GI: gastrointestinal; LOE: level of evidence; SB: small bowel; SOR: strength of recommendation; VCE: video capsule endoscopy.

American Society of Gastrointestinal Endoscopy
In 2017, the American Society of Gastrointestinal Endoscopy released guidelines for the use of endoscopy in the management of suspected small bowel bleeding. These guidelines made the following recommendations on capsule endoscopy (see Table 30).
Table 30. Recommendations on Use of Endoscopy to Manage Suspected Small Bowel Bleeding

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade</th>
<th>QOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>We suggest VCE as the initial test for patients with overt or occult small-bowel bleeding. Positive VCE should be followed with push enteroscopy if within reach or DAE.</td>
<td>Moderate</td>
<td>Very low</td>
</tr>
<tr>
<td>&quot;We suggest DAE or push enteroscopy if VCE is unavailable or nondiagnostic in patients with overt small bowel bleeding.&quot;</td>
<td>Moderate</td>
<td>Very low</td>
</tr>
</tbody>
</table>

DAE: device-assisted enteroscopy; QOE: quality of evidence; VCE: video capsule endoscopy.

American Gastroenterological Association Institute
In 2017, the American Gastroenterological Association Institute issued guidelines on the use of capsule endoscopy. Table 31 summarizes the most relevant recommendations (not all recommendations are included).

Table 31. AGA 2017 Capsule Endoscopy Recommendations

<table>
<thead>
<tr>
<th>Statement Number</th>
<th>Recommendation</th>
<th>Grade</th>
<th>QOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations Supporting the Use of Capsule Endoscopy (CE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>For suspected Crohn’s disease (CD), with negative ileocolonoscopy and imaging studies (CE of small bowel)</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>2</td>
<td>For CD and clinical features unexplained by ileocolonoscopy or imaging studies</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>3</td>
<td>For CD, when assessment of small-bowel mucosal healing (beyond reach of ileocolonoscopy) is needed</td>
<td>Conditional</td>
<td>Very low</td>
</tr>
<tr>
<td>4</td>
<td>For suspected small-bowel recurrence of CD after colectomy, undiagnosed by ileocolonoscopy or imaging studies</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>7</td>
<td>For celiac disease with unexplained symptoms despite treatment and appropriate investigations</td>
<td>Strong</td>
<td>Very low (efficacy) Low (safety)</td>
</tr>
<tr>
<td>8</td>
<td>For documented overt gastrointestinal (GI) bleeding (excluding haematoemesis) and negative findings on high-quality esophagogastroduodenoscopy (EGD) and colonoscopy</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>9</td>
<td>For overt, obscure bleeding episode, as soon as possible</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>10</td>
<td>With prior negative CE with repeated obscure bleeding, repeated studies (endoscopy, colonoscopy and/or CE)</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>11</td>
<td>For suspected obscure bleeding and unexplained mild chronic iron-deficiency anemia, in selected cases</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>12</td>
<td>For polyposis syndromes, which require small bowel studies, for ongoing surveillance</td>
<td>Conditional</td>
<td>Very low (efficacy) Low (safety)</td>
</tr>
</tbody>
</table>

Recommendations Against Use of CE

<table>
<thead>
<tr>
<th>Statement Number</th>
<th>Recommendation</th>
<th>Grade</th>
<th>QOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>For diagnosing CD when chronic abdominal pain or diarrhea are only symptoms, and with no evidence of biomarkers associated with CD</td>
<td>Conditional</td>
<td>Low</td>
</tr>
<tr>
<td>6</td>
<td>For diagnosing celiac disease</td>
<td>Strong</td>
<td>Very low (efficacy) Low (safety)</td>
</tr>
<tr>
<td>13</td>
<td>For routine substitution of colonoscopy</td>
<td>Strong</td>
<td>Very low</td>
</tr>
<tr>
<td>14</td>
<td>For inflammatory bowel disease (IBD), as substitute for colonoscopy to assess extent and severity of disease</td>
<td>Strong</td>
<td>Very low (efficacy) Low (safety)</td>
</tr>
</tbody>
</table>

QOE: quality of evidence; Stmt: statement.

U.S. Multi-Society Task Force
The U.S. Multi-Society Task Force (2017) issued recommendations for colorectal cancer screening with representation from the American College of Gastroenterology, the American Gastroenterological Association, and The American Society for Gastrointestinal...
Endoscopy. Capsule endoscopy every 5 years received a tier 3 ranking with the following recommendation:

“We suggest that capsule colonoscopy (if available) is an appropriate screening test when patients decline colonoscopy, FIT, FIT-fecal DNA, CT colonography, and flexible sigmoidoscopy (weak recommendation, low-quality evidence).”

**U.S. Preventive Services Task Force Recommendations**

The U.S. Preventive Services Task Force published its most recent recommendations for colorectal cancer screening in 2016. Colorectal cancer screening was recommended starting at age 50 years and continuing until age 75 years (A recommendation). Studies evaluating CE were not included in the evidence reviews in this report.

The U.S. Preventive Services Task Force is in the process of updating its recommendations for colorectal cancer screening. The proposed analytic framework in the Draft Research Plan includes the evaluation of CE as a triage test for colonoscopy.

**Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**Ongoing and Unpublished Clinical Trials**

Some currently ongoing and unpublished trials that might influence this review are listed in Table 32.

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01371591</td>
<td>Pilot Study to Investigate the Use of Wireless Capsule Endoscopy for Emergency Department Patients With Suspected Acute Upper Gastrointestinal Bleeding (CHEER)</td>
<td>100</td>
<td>Aug 2018 (unknown)</td>
</tr>
<tr>
<td>NCT03052335</td>
<td>The Comparison of the Efficiency of Colon Capsule Endoscopy and Optical Colonoscopy in Patients With Positive Immunochemical Fecal Occult Blood Test</td>
<td>230</td>
<td>Dec 2019 (recruiting)</td>
</tr>
<tr>
<td>NCT03291743</td>
<td>The Biologic Onset of Crohn’s Disease: A Screening Study in First Degree Relatives</td>
<td>144</td>
<td>May 2021 (recruiting)</td>
</tr>
<tr>
<td>NCT02738359</td>
<td>Efficacy of Colonoscopy, Colon Capsule and Fecal Immunological Test for Colorectal Cancer Screening (FAMCAP)</td>
<td>3250</td>
<td>Nov 2023 (recruiting)</td>
</tr>
<tr>
<td>NCT04307901</td>
<td>Safety of Colorectal Assessment and Tumor Evaluation by Colon Capsule Endoscopy (SOCRATEC)</td>
<td>600</td>
<td>Dec 2030 (recruiting)</td>
</tr>
<tr>
<td>Unpublished</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02754661</td>
<td>Multicenter, Prospective, Randomized Study Comparing the Diagnostic Yield of Colon Capsule Endoscopy Versus Computed Tomographic Colonography in a Screening Population (TOPAZ)</td>
<td>320</td>
<td>Aug 2018 (completed; last updated Oct 2019)</td>
</tr>
</tbody>
</table>

* NCT: national clinical trial.
  * Denotes industry-sponsored or cosponsored trial.

**References**


Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon

Page 52 of 57

42. Hussey M, Holleran G, Stack R, et al. Same-day colon capsule endoscopy is a viable means to assess unexplored colonic segments after incomplete colonoscopy in selected patients. United European Gastroenterol J. Dec 2018; 6(10): 1556-1562. PMID 30574326


**Documentation for Clinical Review**

**Please provide the following documentation:**

- History and physical and/or consultation notes including:
  - Reason for procedure including suspected or known diagnoses
  - Prior endoscopy reports if applicable
  - Evidence of anemia (i.e., CBC) if applicable

**Post Service (in addition to the above, please include the following):**

- Operative/procedure report(s)
- Diagnostic radiology reports

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CPT</td>
<td>0355T</td>
<td>Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report</td>
</tr>
<tr>
<td></td>
<td>91110</td>
<td>Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report</td>
</tr>
<tr>
<td></td>
<td>91111</td>
<td>Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report</td>
</tr>
<tr>
<td>HCPCS</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/13/2002</td>
<td>BCSA Medical Policy adoption</td>
</tr>
<tr>
<td>10/16/2002</td>
<td>BCSA Medical Policy adoption</td>
</tr>
<tr>
<td>11/01/2002</td>
<td>Administrative Review</td>
</tr>
<tr>
<td>06/01/2004</td>
<td>BCSA Medical Policy adoption</td>
</tr>
<tr>
<td>04/01/2005</td>
<td>BCSA Medical Policy adoption Regarding the esophagus; modified, Title change</td>
</tr>
<tr>
<td>01/23/2008</td>
<td>Administrative Review Disclaimer stated added to Medical Policy.</td>
</tr>
<tr>
<td>09/25/2009</td>
<td>Policy Revision</td>
</tr>
<tr>
<td>01/11/2013</td>
<td>Policy revision with position change</td>
</tr>
<tr>
<td>12/15/2014</td>
<td>Policy title change from Wireless Capsule Endoscopy</td>
</tr>
</tbody>
</table>
Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.
**Policy Statement**

Wireless capsule endoscopy of the small bowel may be considered medically necessary when both of the following conditions are met:

I. When the procedure is NOT intended for all of the below:
   A. To evaluate the extent of involvement of known Crohn disease or ulcerative colitis
   B. To evaluate the esophagus, in patients with gastroesophageal reflux or other esophageal pathologies
   C. To evaluate other GI diseases and conditions not presenting with GI bleeding, including but not limited to, celiac sprue, irritable bowel syndrome, Lynch syndrome (risk for hereditary nonpolyposis colorectal cancer), portal hypertensive enteropathy, small bowel neoplasm, screening for colonic polyps or cancer and unexplained chronic abdominal pain
   D. For initial evaluation of patients with acute upper GI bleeding

II. If the procedure is intended for any of the below:
   A. Suspected small bowel bleeding, and both of the following:
      1. Inconclusive upper gastrointestinal (GI) endoscopy during the current episode of illness
      2. Inconclusive lower GI endoscopy (colonoscopy) during the current episode of illness
   B. Initial diagnosis in patients with suspected Crohn disease without evidence of disease on conventional diagnostic tests (such as small bowel follow-through [SBFT] and upper and lower endoscopy)
   C. Established diagnosis of Crohn disease, with unexpected change(s) in the course of disease or response to treatment, suggesting the initial diagnosis may be incorrect and reexamination may be indicated
<table>
<thead>
<tr>
<th><strong>BEFORE</strong></th>
<th><strong>AFTER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D.</strong> For surveillance of the small bowel in patients with hereditary</td>
<td><strong>D.</strong> For surveillance of the small bowel in patients with hereditary</td>
</tr>
<tr>
<td>GI polyposis syndromes, including familial adenomatous polyposis and</td>
<td>GI polyposis syndromes, including familial adenomatous polyposis and</td>
</tr>
<tr>
<td>Peutz-Jeghers syndrome</td>
<td>Peutz-Jeghers syndrome</td>
</tr>
<tr>
<td>Wireless Capsule Endoscopy is considered investigational if the patient's</td>
<td>suggesting the initial diagnosis may be incorrect and reexamination may</td>
</tr>
<tr>
<td>situation does not meet the criteria above.</td>
<td>be indicated</td>
</tr>
<tr>
<td>The patency capsule is considered investigational, including use to</td>
<td>Wireless Capsule Endoscopy is considered investigational if the patient's</td>
</tr>
<tr>
<td>evaluate patency of the GI tract before wireless capsule endoscopy.</td>
<td>situation does not meet the criteria above.</td>
</tr>
<tr>
<td></td>
<td>The patency capsule is considered investigational, including use to</td>
</tr>
<tr>
<td></td>
<td>evaluate patency of the GI tract before wireless capsule endoscopy.</td>
</tr>
</tbody>
</table>