

**Policy: MP252**

**Section: Medical Benefit Policy**

**Subject: Colon Motility Test**

### Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

**I. Policy:** Colon Motility Test

**II. Purpose/Objective:**

To provide a policy of coverage regarding Colon Motility Test

**III. Responsibility:**

- A. Medical Directors
- B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

**Medicaid Business Segment**

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking

into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

#### **DESCRIPTION:**

Colonic motility studies are used to assess the flow of intraluminal contents, the motions of the colonic wall that induce flow, and the control systems that integrate and regulate these processes. Most approaches consist of manometric techniques to record colonic contractions, barostatic methods to measure colonic tone, and recordings of myoelectric signals from the colon that initiate and control muscular contractions.

#### **INDICATIONS:**

The following procedures are considered to be medically necessary:

- colonic manometry
- Defacography when one or more of the following conditions are being evaluated:
  - Chronic constipation
  - Anterior rectocele
  - Enterocele
  - Pelvic floor dysfunction
- Anorectal manometry
- Rectal sensation, tone and compliance testing

#### **MEDICAID BUSINESS SEGMENT:**

Colon motility may be considered medically necessary.

#### **EXCLUSIONS:**

Unless mandated, The Plan does **NOT** provide coverage for the use of any Colon Motility Tests not listed above (e.g., electrogastrography, electroenterography, 3D high-resolution manometry, MRI defecography) for any indication because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this modality on health outcomes when compared to established tests or technologies.

The Plan does **NOT** provide coverage for the use of a wireless capsule for measuring gastric emptying (**SmartPill® GI Monitoring System**) for all indications including but not limited to gastroparesis because it is considered **experimental, investigational or unproven**. Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this testing on health outcomes when compared to established technologies. **(See MP112 Wireless Capsule Endoscopy)**

The Plan does **NOT** provide coverage for the use of Body surface gastric mapping (Gastric Alimetry) for evaluations of gastric motility disorders and all other indications because it is unproven and Not Medically Necessary. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this modality on health outcomes when compared to established tests or technologies.

#### **Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

#### **CODING ASSOCIATED WITH:**

***The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

91117 Colon motility [manometric] study, minimum 6 hours continuous recording [including provocation tests, e.g., meal, intracolonic balloon distension, pharmacologic agents, if performed], with interpretation and report  
91120 Rectal sensation, tone, and compliance test (i.e., response to graded balloon distention)

91122 Anorectal manometry  
91132 Electrogastrography, diagnostic, transcutaneous  
91133 Electrogastrography, diagnostic, transcutaneous; with provocative testing  
0779T Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report  
C9787 Gastric electrophysiology mapping with simultaneous patient symptom profiling {*Gastric Alimetry*}

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

#### **LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

#### **REFERENCES:**

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This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 1/11

**Revised:** 1/18 (Cross-referenced SmartPill exclusion), 1/19 (added covered services); 1/21(add indication and exclusion); 1/24 (add exclusion for alimetry)

**Reviewed:** 1/12, 1/13, 1/14, 1/15, 1/16, 1/17, 1/20, 1/22, 1/23

### **CMS UM Oversight Committee Approval: 12/23**

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.