

Clinical Policy: Fecal Microbiota Transplantation

Reference Number: WA.CP.MP.515

Date of Last Revision: 02/23

Effective Date: 03/01/23

[Coding Implications](#)

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Description

This policy describes the medical necessity guidelines for fecal microbiota transplantation.

Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that fecal microbiota transplantation is considered **medically necessary** when both the following criteria have been met:
 - A. Member/Enrollee has *c. difficile* infection that has failed an appropriate course of antibiotic therapy.
 - B. Provider has obtained adequate member consent consistent with FDA regulations.

- II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that fecal microbiota transplantation is **not medically necessary** for inflammatory bowel disease.

Background

This policy is based on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines. Fecal microbiota transplantation is a procedure where donor fecal material is placed into a patient’s intestine to recolonize it with normal gut bacteria.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen.
44799	Unlisted procedure, small intestine. (Used for instillation by NG tube or enema)

HCPCS Codes	Description
G0455	Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	08/19	08/19
Annual review. Added non-coverage criteria. References updated.	03/20	04/20
Annual review. References updated.	02/21	03/21
Annual review. Changed “not covered” to “not medically necessary”. Changed “members” to “members/enrollees”. Updated references.	02/22	03/22
Annual review. Updated references.	02/23	02/23

References

1. Hasimoto, R., Skelly, A., Brodt, E. (Spectrum Research, Inc.). Fecal Microbiota Transplantation. Washington Health Technology Assessment. September 30, 2016.
2. Washington State Health Care Authority. *Physician-related Services/Health Care Billing Guide*. <https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20230101.pdf> Revision effective January 1, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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