Clinical Policy: Fecal Microbiota Transplantation

Reference Number: WA.CP.MP.515
Last Review Date: 03/20

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

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 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 covered 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
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<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>44705</td>
<td>Preparation of fecal microbiota for instillation, including assessment of donor specimen.</td>
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<tr>
<td>44799</td>
<td>Unlisted procedure, small intestine. (Used for instillation by NG tube or enema)</td>
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Clinical Policy
Fecal Microbiota Transplantation

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tr>
<td>G0455</td>
<td>Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen.</td>
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Reviews, Revisions, and Approvals

<table>
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<tr>
<th>Description</th>
<th>Date</th>
<th>Approval Date</th>
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<tr>
<td>Policy developed.</td>
<td>08/19</td>
<td>08/19</td>
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<tr>
<td>Annual review. Added non-coverage criteria. Reference updated.</td>
<td>03/20</td>
<td>04/20</td>
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References


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.

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**Note: For Medicaid members**, 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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