Fecal Microbiota Transplant

Clinical Coverage Criteria

Overview

A Clostridium difficile infection (CDI) causes intestinal inflammation, diarrhea, and cell death. These infections range in severity from mild symptoms to life threating colitis. Recurrent CDI is defined as an episode of CDI that occurs eight weeks or less after the initial episode that resolved with or without therapy. Initial treatment for CDI is oral antibiotics inclusive of metronidazole and vancomycin.

Fecal Microbiota Transplantation (FMT) is a non-pharmalogical approach for those who failed to respond to oral antibiotic therapies after multiple recurrent infections. FMT refers to the transfer of stool from a healthy donor into the patient's gastrointestinal tract. This is done in order to replace damaged microbiota thus recreating normal and functional microbiota which establishes resistance to further infections.

Policy

Fecal Microbiota Transplantation prior authorization, all the below criteria must be met as supported by the treating provider(s) medical records.

1. The member has had 3 or more recurrent episodes of Clostridium difficile infection as confirmed by positive stool tests. AND
2. The episodes have persisted despite 2 completed antibiotic therapy regimens one of which is inclusive of vancomycin.

Exclusions

- Any use of Fecal Microbiota Transplantation other than outlined above.
- CPT Code 44705 (Preparation of fecal microbiota for instillation, including assessment of donor specimen) is not separately reimbursable.

Codes

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

References

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12. Kim KO, Gluck M. Fecal Microbiota Transplantation: An Update on Clinical Practice. Clin Endosc. 2019 Mar;52(2):137-143. doi: 10.5946/ce.2019.009. Epub 2019 Mar 26.

Policy History

Origination date:	09/01/2017
Approval(s):	Technology Assessment Committee: 05/24/2017 (approved new policy), 05/15/2018 (updated references), 05/22/2019 (updated references)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.