A Framework for Closing CRC Screening Coverage Gaps in Utah

Screen Utah Workgroup 1 Final Recommendations

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As a workgroup formed as part of the One Utah Health Collaborative's Screen Utah initiative, we represent a coalition of healthcare leaders, payers, providers, and policymakers committed to improving the health of Utahns and reducing the rising costs of care. Grounded in the principles of the Utah Model of Care—affordability, quality, and trust—we came together with a shared purpose: to close critical gaps in colorectal cancer (CRC) screening coverage and ensure that eligible Utahns have access to the right test at the right time.

Utah's colorectal cancer screening rates have declined,

falling from 74% in 2020 to below 60% in 2022.

Under the Affordable Care Act (ACA), complete CRC screenings are required to be covered as preventive services with no cost-sharing. Yet inconsistencies in how policies are applied, coded, and billed often lead to surprise bills and confusion—undermining both clinical guidelines and the preventive intent of the law.

CRC remains a leading cause of cancer-related death, and recent data shows Utah's screening rates have sharply declined, falling from 74% in 2020 to below 60% in 2022. This setback, exacerbated by inconsistent reimbursement and billing practices, directly threatens lives and undermines public trust in a healthcare system that should be working *for* patients, not against them.

Through a consensus-based process, the workgroup has identified three clarifications that, if implemented, would bring greater transparency to coverage policies, align clinical intent with reimbursement, and reduce confusion for payers, providers, and patients alike. These recommendations are not just technical adjustments—they are a call to action. They reflect a clear opportunity to re-center our system on prevention, simplify care pathways, and build greater trust through predictable, person-centered care.

Consensus-based Recommendations to Close Screening Gaps

As members of the workgroup, we recommend that Utah healthcare organizations—payers, providers, and other state leaders—adopt the following three clarifications to CRC screening reimbursement policies to ensure that they are consistently covered with no cost-sharing:

1	**Simplify screening reimbursement intervals** for average-risk individuals (e.g. every 10 years for colonoscopy) instead of relying on a complex combination of factors, while maintaining flexibility for high-risk groups with shorter surveillance schedules.
2	**Clarify coverage of screening colonoscopies** to include patients with: - A family history of colorectal cancer, - Incidental or non-emergent symptoms, or - A personal history of precancerous polyps without a prior cancer diagnosis (including surveillance colonoscopies).
3	**Adopt consistent coding and billing practices** that reflect clinical intent (e.g., use of modifiers indicating the procedure is preventive), reducing administrative burden and coverage confusion.

Clarifying Complete Colorectal Cancer Screening (and Why it Matters)

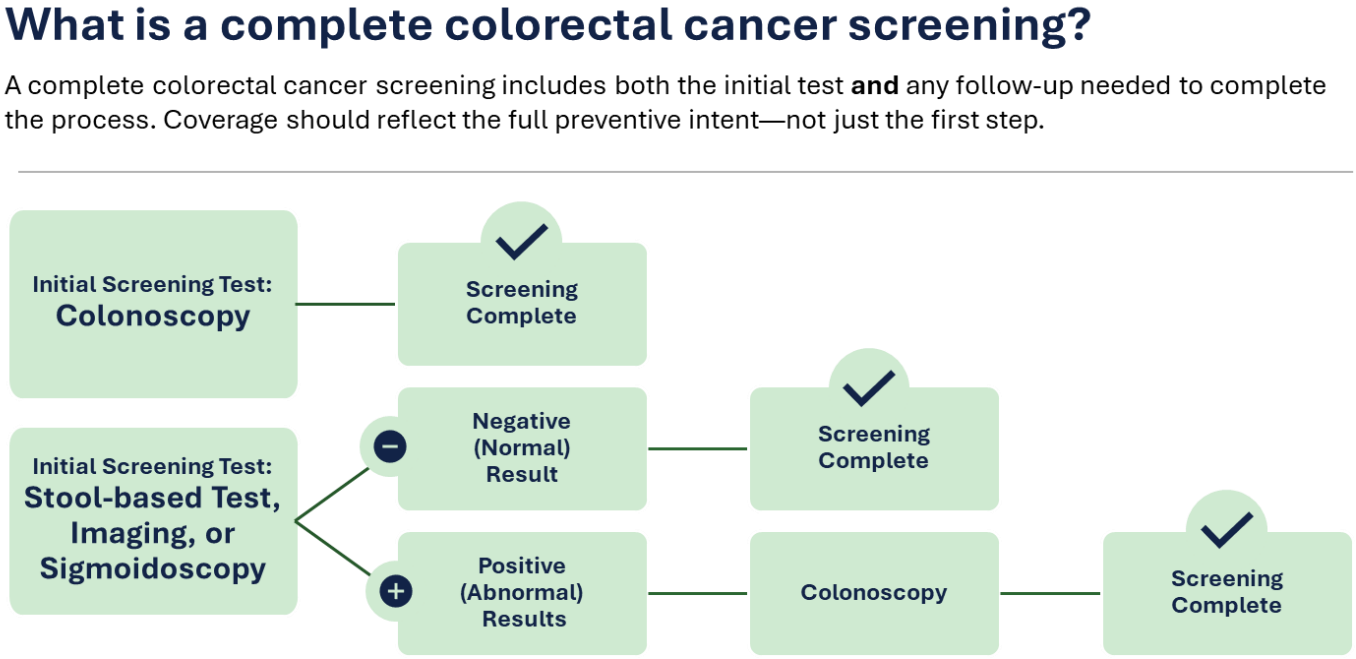
While regulatory coverage requirements set a baseline for CRC screening, they do not prevent stakeholders from offering more comprehensive, clinically aligned benefits. The recommended clarifications do not change who should be screened or when; they align with established clinical guidelines. Their purpose is to ensure that coverage policy reflects clinical intent—supporting eligible Utahns in completing the full screening process, without unnecessary cost or confusion.

A complete CRC screening is a preventive process for individuals without a prior diagnosis of colorectal cancer. It includes both the initial screening test and any necessary follow-up to confirm results and prevent cancer. National guidelines recommend beginning screening at age 45 for average-risk adults, or earlier for those with risk factors.

A complete CRC screening includes:

1. **Initial Screening Test:**
    - May include non-invasive stool-based tests (e.g., FIT, FOBT, Cologuard) or imaging (e.g., CT colonography).
    - May also be a direct visualization exam (e.g., colonoscopy or flexible sigmoidoscopy).
2. **Follow-Up Colonoscopy** (if the initial test is positive and was not a colonoscopy):
    - If a non-invasive test is positive, a timely colonoscopy is essential to confirm results, identify polyps, and remove them if present.
    - When clinically appropriate, services such as polyp removal, biopsy, pathology, or anesthesia are part of this preventive screening—not separate diagnostic services.

Complete CRC screenings are required by the ACA to be covered as a preventive service with no cost-sharing to beneficiaries/patients.



What Utah Organizations Can Do

While the needs and operations of each organization are different, there are meaningful opportunities for payers, providers, and other system leaders to explore ways to move towards this ideal state of CRC screening coverage policies.

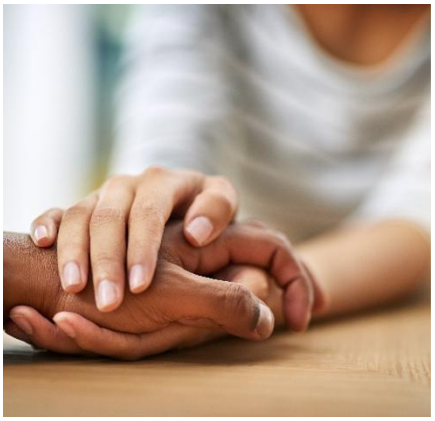
Changes within these organizations could include:

Payers

- **Clarify coverage policies** to ensure beneficiaries receive a complete CRC screening.
- **Eliminate unnecessary cost-sharing** for screenings that are clinically indicated, particularly for high-risk individuals.
- **Ensure benefit managers and claims processors** understand the clinical context and coding implications, minimizing billing errors and denials.
- **Communicate eligibility and cost-sharing** policies with beneficiaries**.**
- **Collaborate with providers** to monitor implementation and adjust policy as needed to reduce barriers to preventive care.
- Establish protocols and systems to **proactively identify beneficiaries** that should be screened and ensure timely follow-up.
- **Modify automated claims processing systems** to recognize screenings, including the use of the 33 modifier to indicate that the service is preventive and should be covered without cost-sharing.

Health Systems & Providers

- **Adopt consistent coding and documentation practices** that reflect the full scope of a preventive screening, including the use of the 33 modifier to indicate that the service is preventive and should be covered without cost-sharing.
- **Educate clinical and billing teams** about policy clarifications and the importance of accurate coding to prevent patients from incurring unanticipated and avoidable costs.
- Establish protocols and systems and empower clinicians to **proactively identify eligible patients** and initiate timely screenings.
- **Participate in quality improvement initiatives** that track screening rates and equity outcomes, reinforcing accountability.
- Train both primary care providers (PCPs) and specialists to **discuss screening options** in a way that supports shared decision-making and reflects patient preferences.
- **Encourage clinical neutrality across screening modalities** (e.g., stool-based tests vs. colonoscopy) to reduce bias and ensure patients receive the right test at the right time.


Health Advocates Across the State

- **Endorse and promote this coverage framework** as aligned with the Utah Model of Care, which emphasizes transparency, prevention, and person-centered care.
- **Convene cross-sector expertise**—including clinical leaders, coding and billing specialists, public health professionals, and patient advocates—to support statewide education, clarify screening pathways, and advocate for policy alignment.
- **Incorporate preventive coverage alignment** into broader initiatives, ensuring that cost-effectiveness and early detection remain priorities.
- **Support public awareness and provider education campaigns** (e.g., in-services) that reinforce the importance of complete CRC screenings.

Why Everyone Benefits

The workgroup believes the time to act is now—not only because it's the right thing to do for patients, but because it makes good business and clinical sense. Our recommendations are designed for both immediate implementation and sustained impact. They challenge each of us—payers, providers, and system leaders—to assess internal policies and practices and align them with a shared vision: one where Utahns receive high-value, preventive care without barriers, delays, or financial harm. By reducing administrative complexity and improving patient outcomes, these changes present a practical and strategic opportunity to strengthen Utah's healthcare system. In doing so, we move closer to a future in which Utah is not only a leader in health innovation, but a model of what's possible when collaboration meets action.

The workgroup believes adopting these clarifications will:

For Payers

- Lower **administrative burden** associated with claims reprocessing, appeals, and inconsistent application of screening policies.
- Improve **screening uptake** by removing cost and access barriers.
- Strengthen **alignment with preventive health goals and quality metrics**, including Healthcare Effectiveness Data and Information Set (HEDIS) measures and population health targets.
- **Build trust** with beneficiaries.

For Health Systems & Providers

- Create **simplified workflows and clearer coding guidance**, reducing billing errors and documentation complexity.
- Result in **fewer claim denials and appeals**, saving time and resources.
- Align with **quality improvement and value-based care incentives**, supporting better outcomes for patients and practices alike.

For Patients

- Lead to **fewer surprise medical bills**, especially for those receiving follow-up colonoscopies after positive stool-based tests.
- Enable **more timely access to screenings** and reduce confusion about what is covered.
- Support **improved understanding and trust** in preventive care systems.

For the State

- Increase **compliance with evidence-based screening guidelines**.
- Advance **Utah's population health objectives**, particularly in cancer prevention and health equity.
- Reinforce the state's goals for **transparent, person-centered, and prevention-oriented care**.

By clarifying what constitutes a complete colorectal cancer screening and aligning coverage accordingly, the workgroup believes Utah will take a significant step toward ensuring that every eligible Utahn can access life-saving care—when they need it, without unnecessary barriers.

This work reflects the shared commitment of board members of the One Utah Health Collaborative to improve colorectal cancer screening in Utah. The recommendations presented here were developed by clinicians, payers, public health leaders, and system experts.

This workgroup includes:

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- ***Cigna Healthcare*** – Dr. Doug Smith, Chief Medical Officer, Market Medical Executive
- ***Comagine Health*** – Dave Cook, State Director of Systemwide Quality Improvement
- ***CommonSpirit Health*** – Dr. Rebecca Vogel, President, Physician Enterprise for Utah
- ***Utah Department of Health and Human Services (DHHS)*** – Marc Watterson, Office Director, Office of Primary Care and Rural Health
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- ***Granite Peaks Gastroenterology*** – Lisa Field, Chief Operating Officer
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- ***SelectHealth*** – Dr. Krista Schonrock, Associate Vice President and Senior Medical Director
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- ***University of Utah Health Plans*** – Geoff Harding, Director of Quality Improvement
- ***Utah Health Information Management Association (UHIMA)*** – Heather Merkley, Program Director
- ***Utah Gastroenterology*** – Christine Morris, Practice Administrator
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Appendices

Appendix A: Screen Utah Background

Screen Utah is a statewide CRC initiative formed to make healthcare more affordable, high-quality, and trusted. As a steward of the Utah Model of Care, the One Utah Health Collaborative (Collaborative) is serving as a convener and partner to help organizations take impactful steps to increasing CRC screenings. Stakeholders across the state are providing engaged leadership, organizational action, and accountability through both self-directed and coordinated actions.

The Screen Utah goal is clear: to increase CRC screening rates across Utah, ensuring that every eligible individual has access to the right test at the right time. More than twenty-four organizations are acting on specific action plans for CRC screenings around the theme: *Connecting patients to the right test at the right time*.

In early 2025, Screen Utah released an Early Action Report that outlined the steps being taken by participating organizations. Through 2025, the Collaborative is engaging monthly with team members from each organization, providing targeted research and analysis support, peer learning exchange opportunities, and supporting further development of these action plans. The Collaborative is also facilitating three workgroups to foster peer learning, alignment with best practices, and shared resources.

Workgroup 1 was formed to identify ways to align payer and provider policies for CRC screening. Efforts of the workgroup included:

- Gathering data on reimbursement policies, clinical guidelines, and best practices
- Convening stakeholders to review findings and make recommendations that will lead to more easily connecting patients at the right time
- Making recommendations to create more clarity and consistency in CRC screening coverage

Members first met in early 2025 to review the coverage policy landscape, known barriers faced by patients across the state, and to align on the ideal outcome of the workgroup's efforts. As the work progressed, the Workgroup met to review findings and consider the policy clarifications.

Through these discussions, the group aligned on the ideal output including a standardized definition of appropriate screening, a coding guide for screening vs. diagnostic procedures, and financial and legal considerations. Research and discussion led the group to the three clarifications noted above. Each clarification was reviewed and discussed as a group and revised based on group feedback.

Appendix B: Additional Context on the Landscape of CRCS Coverage

CRC is the second leading cause of cancer-related death in the United States among men and women combined. Early detection is critical: when diagnosed at its earliest stage, CRC carries a five-year survival rate of 90%. Despite this, more than a third of adults ages 50 to 75 remain unscreened. Rising incidence among younger populations has also prompted updated national guidance, lowering the starting age for screening from 50 to 45.

Beyond the impact on human health, CRC imposes a significant financial burden. In 2020, total annual U.S. medical care costs reached $23.4 billion, with the average cost of treating colon cancer in the first year after diagnosis exceeding $29,000. These costs far surpass the relatively modest expense of preventive screening.

In Utah, earlier public health and clinical interventions drove progress, but screening rates have recently declined. From 2019 to 2020, screening rates fell from 37 to 32.5 per 100,000. Reversing this trend requires coordinated efforts from health systems, public health agencies, payers, and other stakeholders. Collaborative efforts are essential to overcome persistent barriers, including patient access, provider uncertainty, infrastructure limitations, and cost-related deterrents.

The Role of Policy in Advancing Screening

CRC screening is classified as a preventive service under the Affordable Care Act (ACA), requiring coverage without patient cost-sharing for services given an A or B grade by the U.S. Preventive Services Task Force (USPSTF). However, ambiguity remains around the application of these coverage mandates to specific, common scenarios, especially for high-risk individuals and those requiring follow-up services.

Frequently misunderstood scenarios include:

- Colonoscopies following positive home-based tests (e.g., FIT or stool DNA tests), which may be billed as diagnostic despite being part of the screening process.
- The presence of incidental or non-emergent symptoms.
- High-risk individuals that require an earlier screening.
- Removal of polyps during screening colonoscopy, which may trigger unexpected cost-sharing.

In practice, confusion persists across the care continuum—from clinical ordering and patient understanding to coding, claims processing, and policy interpretation. These issues undermine the intent of preventive coverage and deter patients from completing necessary screenings.

Regulatory Review and Identified Gaps

To better understand these barriers, Workgroup 1 reviewed federal and clinical guidance, including USPSTF and professional society recommendations, ACA, and Employee Retirement Income Security Act (ERISA) language, and insights from key stakeholders.

Under the ACA, most health insurance plans are required to cover preventive services—such as colorectal cancer screening—at no cost to the patient if those services are recommended by the USPSTF with an A or B grade. While this requirement was originally established for individual and group plans not governed by ERISA, subsequent amendments to ERISA and related federal regulations extended this same obligation to

employer-sponsored plans. As a result, nearly all non-grandfathered health plans, including those regulated under ERISA, are subject to the same preventive service coverage standards.[1]

In short, even though the rules about covering preventive services CRC screening were first created under the ACA, they were extended to apply to employer-based plans governed by ERISA through legal and regulatory amendments. This ensures consistency across most types of health insurance.

Despite these protections, several persistent gaps remain:

- Lack of clarity on coding and coverage for follow-up colonoscopies after a positive non-invasive screening.
- Inconsistent treatment of screenings involving polyp removal, particularly in Medicare.
- Provider and system-level variation in how diagnostic vs. screening or surveillance colonoscopies are defined and billed.
- Limited education for patients and providers on the implications of coding and coverage classifications.

The adoption of the three recommended clarifications from Workgroup 1 would close many of these, ensuring that patients are connected with the right test at the right time.

Guideline Review

While major CRC screening guidelines are aligned in recommending initiation at age 45 for average-risk adults and emphasizing the importance of early detection, differences in scope and emphasis across these guidelines can lead to gaps in how screening is delivered and covered. For example, USPSTF (which drives insurance coverage policy) recommendations focus on average-risk populations, but they do not address high-risk individuals, such as those with family history or prior polyps. In contrast, specialty organizations like the American College of Gastroenterology (ACG) and the National Comprehensive Cancer Network (NCCN) provide more detailed guidance for higher-risk populations, specifying clinical guidance on screening cadence and frequency. These differences can create gaps between clinical practice, patient communication, and coverage determination—especially when documentation or coding does not clearly reflect the patient's risk status or clinical intent.

This variation presents a meaningful opportunity for greater alignment across guideline interpretation, coverage policy, and provider education. Clarifying how high-risk individuals are identified and covered, standardizing documentation expectations, and ensuring that follow-up procedures remain part of the preventive benefit are all actionable ways to close current gaps. With shared goals across all organizations, efforts to streamline and harmonize these policies can lead to more consistent access, fewer financial barriers, and improved outcomes across diverse populations.

[1] "45 CFR § 147.130 - Coverage of preventive health services" sets forth requirements for non-grandfathered group and individual coverage (not under ERISA) with respect to preventive health services, specifically USPSTF recommendations with an A or B grading. These requirements are codified in 42 U.S. Code § 300gg-13 - Coverage of preventive health services." While ERISA itself doesn't explicitly state the same preventive services requirements apply, certain ACA amendments were incorporated into ERISA and the Internal Revenue Code for enforcement. Notably 29 U.S.C. § 1185d indicates such application to ERISA. 29 CFR § 2590.715-2713 mirrors 45 CFR § 147.130 and explicitly applies the ACA preventive services mandate to ERISA-covered group health plans.

Guideline Body	Recommended Age Range (Average Risk)	Prioritized Modalities	Alternative Modalities	High-Risk Population Guidance	Notable Points
United States Preventive Services Task Force (USPSTF)	45-75 (Grade B); 76-85 (Grade C, individualized)	Colonoscopy (10 years), FIT (annually), Stool DNA-FIT (1-3 years)	CT colonography (5 years), Flexible sigmoidoscopy (5 years), Flexible sigmoidoscopy (10 years) + annual FIT	Applies to average risk adults; high-risk individuals (family history, genetic syndromes) are outside the scope of this recommendation	Emphasizes evidence-based screening to reduce mortality; multiple options to accommodate patient preferences
American Cancer Society (ACS)	Start at 45; continue through 75; 76+ based on individual factors	Colonoscopy (10 years), FIT (annually), Stool DNA-FIT (1-3 years)	CT colonography (5 years), Flexible sigmoidoscopy (5 years)	Recommends earlier and more frequent screening for high-risk individuals	Importance of early detection and multiple modalities to increase adherence
National Comprehensive Cancer Network (NCCN)	Start at 45 for average risk	Colonoscopy (10 years), FIT (annually)	CT colonography (5 years), Flexible sigmoidoscopy (5 years)	Provides some stratification for high-risk individuals, primarily earlier and more frequent screenings	Risk-adapted screening strategies; emphasizes individualized care plans
American College of Gastroenterology (ACG)	Start at 45 for average risk	Colonoscopy (10 years), FIT (annually)	Stool DNA-FIT (1-3 years), CT colonography (5 years), Flexible sigmoidoscopy (5 years)	Earlier screening for high-risk individuals (40), including those with family history or genetic syndromes	Prioritizes colonoscopy and FIT; underscores importance of high-quality colonoscopies
United States Multi-Society Task Force on CRC (USMSTF)	Start at 45 for average risk	Colonoscopy (10 years), FIT (annually)	Stool DNA-FIT (3 years), CT colonography (5 years), Flexible sigmoidoscopy (5-10 years)	Advises high-risk individuals to consult healthcare providers for personalized screening plans	Focuses on public health initiatives to increase screening rates
U.S. Centers for Disease Control and Prevention (CDC)	Aligns with USPSTF	Aligns with USPSTF	Aligns with USPSTF	Advises high-risk individuals to consult healthcare providers for personalized screening plans	Focuses on public health initiatives to increase screening rates

Appendix D: The Business Case for Clarifying CRCS Coverage

Improving clarity around CRC screening coverage isn't just a clinical imperative—it also makes business sense as well. Aligning policy with preventive care guidelines reduces system inefficiencies, lowers downstream costs, and improves quality scores/outcomes.

For Payers:

- Reduces costly complications from late-stage diagnoses by promoting earlier detection.
- Lowers administrative burden from reduced appeals and denied claims due to coding or coverage confusion.
- Improves HEDIS, STAR, and other quality measures by improving preventive screening rates.
- Enhances member trust and retention through better customer experience.

For Providers and Health Systems:

- Decreases time spent on billing errors, denials, and rework.
- Enables more accurate documentation and quality reporting.
- Increases capacity to deliver preventive care rather than high-cost interventions.
- Supports participation in value-based payment models.

For the Health System Overall:

- Enables more timely, appropriate, and targeted care, reducing reliance on late-stage interventions and more complex treatment pathways.
- Aligns with population health goals and reduces disparities in cancer outcomes.
- Builds a more navigable, person-centered system that minimizes financial harm.

Small, coordinated adjustments to coding, coverage policies, and education can yield large returns—financially, operationally, and clinically.

Appendix D: Coding and Classification Considerations for CRC Screening

Clear and consistent coding is critical to ensuring that CRC screening is recognized and covered as a preventive service as intended under national guidelines. When codes are misapplied or interpreted inconsistently across systems, patients may face confusion along with unnecessary costs and delays—and providers and payers experience greater administrative burdens.

Possible causes of misclassification and billing errors include:

- **Screening Followed by Diagnostic Reclassification:** When a patient completes a stool-based screening test at home and receives a positive result, the follow-up colonoscopy is still considered part of the original screening. However, some payer systems or provider billing practices may incorrectly classify this follow-up as a diagnostic procedure, leading to cost-sharing for patients.
- **Coding Based on Procedures Rather than Clinical Intent:** If a colonoscopy begins as a screening but results in the removal of a polyp or includes biopsy or anesthesia services, the claim may be processed as diagnostic. While these actions are part of a thorough screening process, billing systems may misinterpret them as diagnostic care unless documentation and modifiers reflect the original preventive intent.
- **Use of Symptom-Based Diagnoses:** If a provider documents symptoms such as rectal bleeding or abdominal pain—even in a patient eligible for preventive screening—the procedure may be categorized as diagnostic. *This reinforces the importance of documenting whether the colonoscopy was initiated as a preventive measure, particularly when symptoms are incidental*.
- **Surveillance vs. Screening Confusion:** Patients with a history of polyps or other risk factors may undergo "surveillance" colonoscopies. Lack of clarity in documentation or inconsistent payer definitions of surveillance timelines can lead to denials or incorrect cost-sharing.
- **Facility vs. Professional Coding Discrepancies:** Facilities and individual providers often operate under different coding systems and guidelines. This can result in mismatched billing between hospital and physician claims for the same procedure, triggering reprocessing, patient confusion, or surprise bills.

To reduce these misclassification and billing errors, payers and providers should invest in standardized education tools for patients, and support providers with coding guides and workflows that reinforce clear documentation of clinical intent and procedure type.

Opportunities for system-level improvement include:

- **Align Definitions and Policies:** Establish consistent definitions of "screening" and "diagnostic" colonoscopies across payers, facilities, and providers. Clarify that follow-up colonoscopies after positive home-based tests are part of the "complete screening" preventive process.
- **Improve Documentation Practices:** Encourage providers to clearly note the clinical reason and intent for procedures. This can prevent misclassification when symptoms are present but not the primary reason for the visit. Consider consistent guidance of documenting the screening modifier to clearly indicate clinical intent.
- **Standardize Communication and Education Materials:** Develop clear, concise materials to help patients understand what to expect from CRC screening—including possible follow-ups, what is considered part of the screening, and how costs are determined.
- **Reduce Administrative Friction:** Payers can adjust claims processing rules to reflect preventive intent and avoid automatic reclassification. Providers can implement consistent workflows to improve billing accuracy and reduce denials.