When Coding Meets Coverage: How Outdated Policies Created Ethical Challenges in Colonoscopy Billing

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For years, colon cancer screening guidelines recommended a pathway that began with a stool-based test such as a FIT or stool DNA test. When those tests returned a positive result, patients were advised to complete a follow-up colonoscopy—a clinically necessary step to determine whether colorectal cancer or advanced adenomas were present.

Patients reasonably believed this entire process was preventive and therefore covered by their insurance. Unfortunately, before 2023, coverage policy didn't align with clinical intent. Instead of classifying follow-up colonoscopies as part of the screening continuum, many payers labeled them as **diagnostic**, resulting in unexpected out-of-pocket costs.

For coding professionals and physicians, this misalignment created a difficult ethical landscape. We were required to assign accurate diagnostic codes, yet we also witnessed the frustration, confusion, and financial stress these bills caused for patients who had done everything "right" according to preventive screening recommendations.

The Gap Between Clinical Logic and Coverage Policy

A FIT test and its follow-up colonoscopy are two halves of one clinical process. If the first test signals a possible problem—whether ultimately correct or not—the next step is medically necessary. For years, however, insurers viewed the diagnostic colonoscopy as a *diagnostic* service, applying co-pays, co-insurance, or deductible amounts that patients didn't expect.

False positives added to this complexity. Clinical studies show that **approximately 13%** of patients without colorectal cancer or advanced adenomas receive a false-positive FIT result. For those patients, the emotional and financial toll of undergoing a colonoscopy—followed by being billed for it—created even deeper frustration.

As a coding manager, I frequently received inquiries from billing staff asking whether the colonoscopy could be coded as preventive on behalf of confused patients. But coders are obligated to follow payer policy and coding guidelines—not patient preference. This created a consistent ethical tension: **the correct code wasn't aligned with what felt fair or logical to the patient.**

Patient Financial Impact

This wasn't a rare issue. A 2021 JAMA study found:

- **48% of commercially insured patients** and
- **78% of Medicare patients**

paid something out-of-pocket for follow-up colonoscopies after a positive FIT.
Their mean costs ranged from **$99–$231**, but many paid significantly more depending on their deductibles.

Financial barriers had measurable downstream effects. In many health systems, fewer than half of patients completed a follow-up colonoscopy within the recommended window—despite a positive screening result.

For both physicians and coding professionals, this was deeply concerning. If cost becomes a deterrent to completing the screening pathway, the system is failing the very patients it aims to protect.

Ethical Challenges for Coding Professionals & Physicians

This pre-2023 environment highlighted several ethical themes familiar to both clinicians and HIM professionals:

1. Doing what's best for the patient

Clinically, physicians knew the follow-up colonoscopy was necessary. Coding professionals knew the data supported preventive classification. Patients expected continuity of coverage.

2. Avoiding harm

Financial harm—surprise bills, unexpected deductibles, or anxiety over costs—was an unintended consequence of an outdated classification.

3. Justice and fairness

Patients were penalized for complying with recommended screening protocols.

4. Professional integrity

AHIMA's Code of Ethics instructs professionals to refuse to engage in or conceal unethical practices. While coders couldn't override policy, we could advocate for clearer guidelines and highlight where patient harm was occurring.

The tension wasn't between coders and clinicians—it was between **clinical reality and payer policy**.

The 2023 Policy Shift: Aligning Practice and Coverage

On January 1, 2023, CMS implemented a major update (MM13017), stating:

"We now understand both the non-invasive stool-based test and the follow-on colonoscopy are part of a continuum of a complete colorectal cancer screening."

This officially reclassified follow-up colonoscopies after a positive stool test as **screening**, not diagnostic.
Cost-sharing was eliminated for Medicare beneficiaries, and many commercial payers followed suit.

This change brought long-overdue alignment between:

- clinical practice
- coding logic
- preventive care guidelines
- patient experience
- and ethical principles

Removing cost-sharing had immediate effects. A University of Michigan IHPI study reported a **41% increase** in completed follow-up colonoscopies after the policy change.

What This Means for Coding Professionals and Physicians

The CMS policy correction is a powerful reminder that coding accuracy is not just a technical skill—it's deeply tied to **patient access, equity, and ethics**.

For physicians

- Documenting the rationale for colonoscopy after a positive FIT is now more straightforward.
- Patients can proceed with recommended care without financial hesitation.

For coding professionals

- Assigning accurate codes is still essential, but we must also:
    - stay current with policy changes,

- educate providers and billing staff,
- identify systemic barriers, and
- advocate for fair coverage.

For both groups

This case demonstrates how clinical practice, payer policy, and coding intersect—and how misalignment can unintentionally harm patients.
It also proves that **targeted advocacy works**. Coding professionals, clinicians, researchers, and patient organizations all contributed to changing a national policy that now benefits millions.

Conclusion: Ethical Coding Is Patient-Centered Care

When coding reflects clinical reality and policy supports preventive care, patients win. The 2023 CMS update corrected a long-standing gap, ensuring fairness and removing barriers that previously discouraged necessary follow-up.

For coding professionals and physicians, this moment illustrates our shared responsibility:

- follow the guidelines,
- advocate for patients,
- collaborate across disciplines,
- and push for system-level changes when policy lags behind science.

Ethical coding isn't just about accuracy.
It's about **integrity, advocacy, and doing what's right for the patient.**

HCPCS, CPT, and ICD-10-CM Coding — Screening Colonoscopy After a Positive FIT/Cologuard Test (2023 and Beyond)

Example 1 — Positive Cologuard → Low-Risk Screening Colonoscopy (Normal Results)

Medicare Patients

- **HCPCS & Modifier: G0121-KX**
- **ICD-10-CM:**

- **Z12.11** — Encounter for screening for malignant neoplasm of colon
- **R19.5** — Other fecal abnormalities

Commercial / Medicaid Patients

- **CPT & Modifier: 45378-33**
- **ICD-10-CM:**
  - **Z12.11** — Encounter for screening for malignant neoplasm of colon
  - **R19.5** — Other fecal abnormalities

Understanding Modifiers 33, KX, and PT

- **Modifier 33 — Preventive Service**

Used for **commercial and Medicaid plans**

- Indicates the service is preventive under ACA rules
- Helps trigger no-cost-sharing when payer policy supports preventive coverage

- **Modifier KX — Documentation Requirement Met**

Used for **Medicare** on screening colonoscopies after a positive FIT/Cologuard

- Required per CMS after policy MM13017
- Indicates the service meets CMS criteria for screening status

- **Modifier PT — Screening Converted to Diagnostic/Therapeutic**

Used **primarily for Medicare**

- Indicates a screening colonoscopy in which a therapeutic service (e.g., biopsy, polypectomy) was performed