Sage Provider Manual

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Overview

The Sage Screening Program is a partnership between the Minnesota Department of Health and health care providers. The goal of the Sage Screening Program is to provide access to quality breast and cervical cancer screening for Minnesota patients with low to moderate-income, who are un- or under-insured. The program is funded through a cooperative agreement with the Centers for Disease Control and Prevention under the "Breast and Cervical Cancer Mortality Prevention Act of 1990," (DP22-2202) as well as funds from the State of Minnesota.

Eligibility

Patient eligibility can be determined two ways.

1. Patients can learn if they qualify for Sage services by calling the Sage Phone Center at 1-866-643-2584. A three-way call will take place between the patient, Sage Phone Center and clinic scheduler. If a patient is scheduled for an appointment via the Sage Phone Center, the clinic should honor the eligibility status that was granted during the phone call.
2. Patients can learn if they qualify for Sage services by working directly with the Sage clinic. If the provider is solely determining patient eligibility, this should be done prior to the patient completing the Sage enrollment form.

Providers must not charge enrolled patients for Sage-covered services. If a provider enrolled a patient into Sage but they are not deemed eligible by Sage staff, the clinic is responsible for any patient bill.

Patients must meet all four eligibility criteria listed below:

1. Age

2. Ages 40-74 for breast and 21-64 for cervical cancer screening
    a. Exceptions: Patients under 40 (30-39) years old are eligible for breast cancer *diagnostic* services if they meet at least one of the following conditions:
3. The patient is experiencing signs or symptoms that may be related to breast cancer (i.e., lump, bloody nipple discharge, skin dimpling, inflammation) and diagnostic work-up is important to rule out this possibility.
        i. The patient reports a family history of breast cancer in a first-degree relative (parent, sibling, or child). Patients with a first degree relative diagnosed at a young age with breast cancer should begin testing within 10 years of their relative's age at diagnosis (Sage may be able to cover the diagnostic costs for these patients if they are otherwise qualified for the program).
        ii. Patients who were born female or who are transgender male or female and meet all other program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services through the Sage Screening Program. All individuals eligible to receive Sage services will be referred to as "patients" throughout the remainder of this manual.

4. **Have no insurance or are under-insured**

    a. Underinsured refers to an eligible patient who has any co-pay or deductible. Co-pays are not to be collected from Sage enrolled patients. Primary insurance can be a commercial plan or MinnesotaCare. Patients with a Health Savings Account are eligible for Sage. Sage will pay for screening services instead of the HSA. Patients with a Medicaid Spenddown may qualify for the Sage Program.

5. **Have a Minnesota or adjacent state address**

    a. Patients who live in Minnesota, either year-round or seasonally, are eligible for Sage Screening Program services if they meet the program's age, income and insurance guidelines.

    b. Patients who do not have a Minnesota address should be referred to the Breast and Cervical Cancer Early Detection Program in their state of residence to determine eligibility for services in their own state's program. Phone numbers for other state programs can be obtained by calling 1-888-643-2584 or by visiting CDC: Find a screening program.

    c. Patients with a non-Minnesota address in adjacent states (WI, IA, ND, SD) are eligible for the Sage Screening Program if they meet Sage's age, income and insurance guidelines. These patients are NOT eligible for treatment coverage under the Minnesota Treatment Act and may become ineligible for coverage under their state's Treatment Act due to participating in the Sage Program.

6. **Annual income at or below 250% of the federal poverty level (based on income and family size)**

    Income guidelines change annually around February and are listed on the Sage website: Sage Eligibility (www.health.state.mn.us/diseases/cancer/sage/documents/eligibility.pdf).

Covered services

The following services may be covered by Sage for eligible patients at participating facilities.

Sage will pay for one office visit CPT charge for each eligible patient per date of service. Sage will pay for one office visit CPT per date of service billed on a professional claim OR one office visit CPT per date of service billed on an institutional claim.

Screening services

1. Office visit for breast exam and/or breast health education and cervical exam

2. Pap test

Patients ages 21-64 can receive:

1. A Pap test every three years with reflex testing; or
2. A Pap test in combination with HPV testing (Human Papillomavirus testing, also called co-testing) every five (5) years; or
3. HPV-testing alone (also called primary HPV testing) every five (5) years
    a. Patients who have had a total hysterectomy (i.e., those without a cervix), should not have a Pap test done under the Sage Program; unless:
        i. The hysterectomy was performed because of cervical neoplasia (CIN) or invasive cervical cancer.
        ii. It was not possible to document the absence of neoplasia or reason for the hysterectomy.
        iii. Note: Below are the medical recommendations regarding screening for patients who have had a hysterectomy for CIN or cervical cancer:
            - Patients who have had a hysterectomy for CIN disease should undergo cervical cancer screening for 20 years even if it takes them past the age of 65 (patient must meet eligibility criteria for coverage under the Sage Program).
            - Patients who have had cervical cancer should continue screening indefinitely, as long as they are in reasonable health.
            - For patients who have had a total hysterectomy for non-cancer reasons, Sage supports the recommendation of a yearly pelvic exam along with a breast exam. However, Sage cannot pay for an office visit in which only a pelvic exam is done.

3. Screening mammogram

Patients ages 40-74 can receive a screening mammogram, which may be accompanied by a clinical breast exam (CBE) done at a Sage Screening Program participating clinic. Clinical breast exams are recommended but no longer required by the Sage Program.

- Computer-Assisted Detection (CAD) with mammography
- Tomosynthesis (3-D mammography)

Diagnostic services

Diagnostic services provided to patients whose initial screening result indicates the need for additional evaluation to rule out cancer.

Follow-up office visits

Repeat clinical breast and cervical exams as often as clinician recommends (Sage cannot cover an office visit for a pelvic exam only).

1. An office visit to discuss abnormal results; provided the abnormal test finding was the result of a Sage screening.
2. Surgical consultation to work up abnormal suspicious breast finding.

Breast diagnostic services

1. Diagnostic mammogram (including CAD and Tomosynthesis)
2. Breast ultrasound
3. Fine needle aspiration (including pathology)
4. Outpatient breast biopsy
5. The Sage Program will cover costs normally associated with outpatient breast diagnostic procedures, including surgical consultation, biopsy, anesthesiology, pathology, lab work, and pre-op exams or consultation. To be covered, all services must occur on an outpatient basis. All individuals and organizations involved in the breast diagnostic procedures must be contracted with Sage and bill with the patient's Sage encounter number. Each of these organizations should submit charges to Sage for reimbursement. Sage enrolled patients must not be billed for co-pays or deductibles for diagnostic services. For questions, please contact your Sage Follow-up Coordinator.
6. Excision of breast lesions
    a. Breast excisions can be covered in limited situations and should be pre-approved by a Sage Follow-up Coordinator. **After a diagnosis of Fibroadenoma (FA) is established with tissue sampling (biopsy) or diagnostic imaging, an excision of the FA may be covered in the following instances only**:
        i. Hyperplasia or atypical cells on pathology.
        ii. Large size: 5 cm or greater (this can obscure a malignancy).
        iii. Change in size or appearance as demonstrated on 6-month imaging follow-up.
        iv. To rule out a Phyllodes tumor.
7. **Sage will not cover excision for patients' comfort or for aesthetic reasons.**

Cervical diagnostic services

1. Colposcopy of the cervix (including biopsy and histological endocervical sampling (ECC), endocervical curettage (ECS), or any combination of these.
2. For patients with documentation of a recent prior abnormal pap test result indicating the need for colposcopy, or prior abnormality requiring surveillance.
3. Endometrial biopsy
    a. For patients whose cervical screening result is any Atypical Glandular Cell (AGC) finding (examples: Atypical Endocervical Cells, Atypical Endometrial Cells; Atypical Glandular Cells, or Endometrial Cells in a woman aged 40 or older, and Adenocarcinoma).
4. HPV testing
5. HPV testing is done alone or in conjunction with a Pap test (co-testing) or if it is done at the lab if a Pap result is ASCUS (reflex testing). A patient may be enrolled for a Sage office visit with only an HPV testing completed.

Periodicity of covered services

Cervical screening

The Sage Program covers:

1. Pap tests with reflex testing every 3 years for patients ages 21– 64
2. Pap tests every 5 years in combination with HPV co-testing for patients ages 21– 64
3. Primary HPV testing (HPV test alone) every 5 years for patients ages 21– 64
4. Follow-up for abnormal cervical screening
5. Following an abnormal Pap test and/or HPV testing results, Sage will cover all testing or re-testing according to the time frames established in the American Society for Colposcopy and Cervical Pathology Updates Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors, which can be found online at ASCCP (www.asccp.org).

Pelvic exam

The Sage Screening Program will pay for an office visit for a pelvic exam, if during the office visit:

1. A Pap test is collected according to the Sage Pap periodicity policy
2. A clinical breast exam (CBE) is performed
3. Both a Pap and CBE are performed
4. In lieu of a CBE, education regarding breast health and breast cancer screening are provided, and a mammogram is ordered

Breast screening

The Sage Program covers:

1. Breast exam and/or breast health education with screening mammogram every year
2. Screening mammogram every year
3. Follow-up/diagnostic testing for abnormal breast cancer screening*

   *Please consult with Sage Follow-up Coordinator for additional information

Services not covered by the Sage Screening Program

Only the services listed above are covered. Some services that are commonly billed to the Sage Screening Program, but are **not covered** include:

1. Breast MRI
2. Evaluation of vaginal or vulvar lesions
3. Removal of cervical polyps
4. Blood work
5. Urinalysis
6. Pelvic ultrasounds
7. Endometrial biopsy if done for vaginal bleeding work-up
8. Any type of treatment for cancer or precancerous lesions (refer to MA-BC)

Tracking and follow-up

A crucial component of the Sage Screening Program is to ensure that patients with abnormal screening results, or patients who have a diagnosis of cancer, receive timely and appropriate diagnostic, treatment, and rescreening services. Sage Screening sites are expected to maintain a system to enable them to track patient results, notify patients of their test results, follow-up with patients with abnormal results, and remind patients to return for rescreening.

Normal test results

Screening sites should communicate normal test results to patients in writing or by telephone within ten days of receipt.

Abnormal test results

Screening sites should attempt to notify a patient of an abnormal test results within 5 days of receipt. Several attempts to notify a patient should be made by phone. If you're unable to reach a patient by phone, a certified letter may be sent. All dates and attempts to reach a patient, as

well as the follow-up recommendations, should be documented in the patient's medical record. The recommendations and a plan for follow-up should be clearly communicated to the patient.

Assisting patient to obtain diagnostic/treatment services

Securing diagnostic and/or treatment services for underinsured/uninsured patients can be a challenge. It can involve the provision of follow-up care at the screening site, or a referral to an outside provider. If the service needed is a Sage covered service a referral should be made to a Sage provider who can provide this service. For a current list of participating Sage Providers, visit our website at www.mnsage.com.

Sage Screening sites are expected to track patients with abnormal test results until they receive all their diagnostic/treatment services. Sage Screening sites should have a plan to assist patients with abnormal test results so they can receive the recommended care. Sites are expected to work with each patient to ensure that they understand the need for follow-up and know where and how to access these services. Sites should be aware of the resources available to patients (including MNSure and MA-BC), and how to access these services. The Sage Screening Program Follow-up Coordinator can assist you in identifying resources for patients.

Before considering a patient as lost to follow-up, there should be a minimum of three separate attempts to contact the patient, the last attempt being through certified mail. Contact should be attempted at various times of day, and on various days of the week. **The Sage Follow-up Coordinator is also available to try to reach patients otherwise considered lost to follow-up.**

For patients requiring treatment, coverage may be available through the Minnesota Department of Human Services Medical Assistance for Breast or Cervical Cancer Patients Program (MA-BC); enrollment in Medical Assistance, Minnesota Care, or other financial assistance programs (such as through a health system) or setting up a payment plan. A limited number of additional resources have been identified by the Sage Screening Program, but these vary by locale. Contact your Sage Follow-up Coordinator for questions and assistance.

Patient tracking

To assure that patients with abnormal screening results receive timely and appropriate follow-up, the Sage Screening Program actively tracks the care received by patients with abnormal screening results. The following findings are tracked:

1. Breast exam finding of "suspicious for cancer"
2. Mammogram result of "Assessment Incomplete," "Suspicious," or "Highly Suggestive of Malignancy"
3. Any breast diagnostic procedure- ultrasound, fine needle aspiration, or biopsy
4. Pap test results of ASC-H (Atypical Squamous Cells: cannot rule out High Grade), LSIL (Low Grade Squamous Intraepithelial Lesions), High Grade Squamous Intraepithelial Lesion (HSIL), Atypical Glandular (AGC), Adenocarcinoma, Squamous Cell Carcinoma, and positive High-Risk HPV

5. Any colposcopy

The Sage Screening Program tracks outcome information on all patients with abnormal test results by way of the "Sage Abnormal Breast Screening Follow–up Report" and the "Sage Abnormal Cervical Screening Follow up Report." The Sage Follow up Coordinator will generate and send these forms to the clinic's follow-up contact at the screening site approximately 30 days after the abnormal test. This form should be completed by the health professional involved in the patient's care and returned to Sage within two weeks. Instructions for completing the Abnormal Follow-up Report are found on the back of each follow-up form. When completing the follow-up form, be sure to document all diagnostic/treatment procedures and the date(s) of completion, results and the status of the diagnostic work-up. If you are unable to provide the outcome information, please provide the name, address, and phone number of the physician to whom this patient's care has been transferred to in order to enable Sage to request follow-up information from that provider. If you have difficulties getting the patient to return for follow-up care, please note in the comment section and return the form to the Sage Program Follow-up Coordinator via email or fax.

Through the information provided on the follow-up reports, the Sage Screening Program monitors the follow-up care provided to patients using guidelines developed by its Medical Advisory Committee. Providers may be contacted for additional information when questions arise, or if the care provided falls outside of what's expected. The Sage Screening Program's expectation is that diagnostic care and treatment be provided as soon as possible. The Sage Screening Program's goals for both breast and cervical abnormalities are:

- Breast abnormalities: A diagnosis is reached within 60 days of an abnormal screening. Treatment is initiated within 60 days of diagnosis.
- Cervical abnormalities: A diagnosis is reached within 90 days of an abnormal screening. Treatment for invasive cancer is initiated within 60 days. Treatment for high grade lesions is initiated within 90 days of diagnosis.

Rescreening

Sage Screening sites should remind patients to return for rescreening as their recommended rescreening date approaches. Screening sites may wish to coordinate reminders with the mammography providers, as many mammography providers routinely remind patients directly.

Coverage of treatment services

Patients who have been screened through the Sage Screening Program and need treatment for breast cancer, cervical cancer, or a pre-cancerous cervical condition, may be eligible for a treatment resource program to cover the costs of the needed treatment.

The Minnesota Department of Human Services has established a category of Medical Assistance (MA) called "MA-BC" which has eligibility guidelines that are designed specifically for Sage patients who receive a diagnosis of breast and/or cervical cancer or pre-cancer. The eligibility criteria for patients are: 1) screened through the Sage Screening Program (eligible for the program at the time of diagnosis); 2) under age 65; 3) no creditable insurance to cover treatment costs, and 4) an immigration status that qualifies for either federal or state MA. Patient application forms for MA-BC are available on the Minnesota DHS webpage (Medical Assistance for Breast or Cervical Cancer / Minnesota Department of Human Services).

MA-BC also offers a Presumptive Eligibility component. This allows a patient who has been screened through the Sage Screening Program and found to need treatment a 60-day period of automatic coverage, regardless of ultimate eligibility for MA-BC. Even if a patient is determined by the county to be ineligible for MA-BC (after filing an application) any treatment costs incurred during the Presumptive Eligibility period will still be covered. To learn more about the Presumptive Eligibility for MA-BC, contact your Sage Follow-up Coordinator.

Enrolling patients in Sage – the Sage enrollment form

Eligible patients enroll in the Sage Screening Program by completing pages 1 - 3 of the Sage enrollment form (available in English and Spanish) and signing and dating the consent at the bottom of Page 1. The clinic assigns an **encounter number** which should be placed on the enrollment form, Pap Summary, Imaging Summary, and any other related Sage forms, **and must appear on all related bills submitted to Sage.** Encounter numbers are unique to each screening site, and each Sage office visit requires the use of a new encounter number.

Providers must not charge enrolled patients for Sage-covered services. If a clinic enrolled a patient into Sage but they are not deemed eligible by Sage staff, the clinic is responsible for any patient bill.

Information completed by the patient

Pages 1 – 3 of the Sage enrollment form should be completed by the patient before their Sage exam. Please note that a patient cannot be enrolled in Sage without a completed “Permission for Release of Information” (program consent) with a current date. The permission provides information to the patient on how the clinic and Sage will use the information collected on the form, and it allows providers to release the required medical information to the Sage Program.

The Sage visit summary (completed by the clinician)

Once enrolled, the patient may have a clinical breast examination (and Pap test, if indicated) by a clinician at a Sage Screening Program screening site before receiving a mammogram. The

exam may be done by a physician, nurse practitioner, physician associate or nurse-midwife and should include cancer screening information. The clinical breast exam is optional, but an office visit must be completed.

If breast screening isn't necessary, a cervical screening only visit is acceptable.

Upon completion of the Sage Screening Program patient visit, the clinic must complete the Visit Summary portion of the Sage enrollment form on page four. Please retain a copy of the Sage enrollment form for the clinic records, and email or fax the original copy to the Sage Screening Program within 2 weeks of the date of service. **The Sage Screening Program will not accept forms later than 120 days after the date of the office visit.**

Upcoming change in forms submission process

The Sage Program is in the process of going 'paperless.' This will involve Sage Program staff training all Sage clinics to use our online Portal to submit data to Sage, instead of completing and submitting paper forms. All Sage clinics will be required to adopt this new process. More information will be shared when it is available.

Re-enrolling patients in Sage

Patients are enrolled and re-enrolled in Sage through a Sage enrollment form. Each Sage office visit requires a new Sage enrollment form and a new encounter number. The Sage consent (page 1 of the Sage enrollment form) must be signed yearly, and patients should be reassessed for eligibility at each return visit.

Referring for mammograms and ultrasounds

This section provides direction to Sage Screening sites making a referral for imaging services through the Sage Screening Program. For information for those working in mammography/ultrasound facilities and/or radiology groups, see "Imaging Services."

Screening mammogram

After the screening site has enrolled the patient in Sage, the screening site can schedule the mammogram and send the Sage encounter number to the imaging facility. This can be done either by sending the mammography facility a Sage Imaging Summary with the patient's name and encounter number, or by giving the imaging provider the patient's encounter number so they can initiate the Sage Imaging Summary Form. The ordering physician will receive their usual mammography report, and Sage will also receive the patient's results.

Breast ultrasound

After the screening site has enrolled the patient in Sage, they can schedule the breast ultrasound and send the Sage encounter number to the imaging facility. This can be done either by sending the mammography facility a Sage Imaging Summary with the patient's name and

encounter number, or by giving the imaging provider the patient's encounter number so they can initiate the Sage Imaging Summary Form.

Follow up/short term mammograms and/or breast ultrasound

The Sage Screening Program will reimburse for short term (i.e., 3 – 6 month) follow-up breast imaging mammogram, and/or breast ultrasound recommended to follow up a "Probably Benign" (ACR category 3) finding. For follow-up breast imaging, a Sage enrollment form ***with a new encounter number*** should be completed, either by the screening site or by the Imaging facility that has been designated by Sage with enrollment capabilities. The patient's consent is valid for 12 months. The mammogram/ultrasound date should be recorded as the visit date, and under the "mammogram ordered or done", or "breast ultrasound ordered or done" questions, what imaging was provided should be checked. A new Sage Imaging Summary Form needs to be completed (for each imaging service) and sent to Sage (by the Imaging provider).

Cervical screening

This section provides information to the Sage Screening Program screening sites for handling lab services ordered through Sage. Guidance for cytology laboratories and pathologists can be found under "Lab Services".

Pap testing

The Sage Screening site enrolls the patient in Sage and assigns an encounter number. The site then does an exam and sends a Pap or specimen to the lab with the patient's encounter number noted, on a Pap Summary Form (unless alternate reporting arrangements have been made). The ordering physician will receive their usual Pap result, and Sage will also receive the patient's result. The clinic is responsible for notifying the patient of the results.

Colposcopy

Sage will reimburse for colposcopy (with cervical biopsy and/or histological endocervical sampling (ECC or ECB), or both. Patients must have a documented recent abnormal Pap test indicating the need for colposcopy or a prior abnormality requiring surveillance. Patients can be enrolled at colposcopy if not previously enrolled in Sage, and eligibility criteria are met.

Endometrial biopsy

Sage will reimburse for an endometrial biopsy if the Pap test was a result of ACG or an incidental finding of endocervical cells in a patient 40–64. Patients can be enrolled at endometrial biopsy is Sage eligibility criteria are met, and there is confirmation of Pap result that meets criteria.

Coordinating with other providers

Sage Program staff are available for assistance in coordinating care between Sage contracted providers.

Referral outside the Sage screening sites facility

Some Sage Screening Program providers may not offer one or more of the follow-up services that the Sage Program will pay for (i.e.: colposcopy). When this occurs, the patient should be referred to another Sage participating facility that offers the necessary service. You can get a list of Sage locations on our provider webpage at Sage Screening Clinics.

Outside breast diagnostic procedures

Sage Screening Program will cover all costs normally associated with an outpatient breast diagnostic procedure, including surgical consultation, biopsy (whether open surgical, needle localization or stereotactic), anesthesiology, pathology, radiology, lab work and pre-op exam or consult. For questions on covered biopsy services, contact Sage at 651-201-5600.

All providers (surgeon, radiologist, hospital, anesthesiologists,) involved in patient care must be contacted and given the Sage encounter number. The patient should not be charged a co-pay or deductible. Each of these organizations should submit charges to Sage for reimbursement.

Imaging services – Imaging provider information

This section addresses the specific issues and paperwork related to mammography facilities, ultrasound providers and radiology groups that provide Sage Screening Program services.

Patients are enrolled in the Sage Program through a participating Sage Screening clinic. Exceptions to clinic enrollment: Imaging facilities designated by the Sage Screening Program to enroll patients as “Mid-Cycle” sites can enroll eligible patients who require diagnostic imaging services. Contact the Sage Coordinator if your Imaging Facility is interested in learning more about becoming a mid-cycle enrollment site.

The Sage Screening Program will reimburse for short term (i.e., 3 – 6 month) follow-up breast imaging mammogram, and/or breast ultrasound recommended to follow up a "Probably Benign" (ACR category 3) finding. For follow-up breast imaging, a Sage enrollment form ***with a new encounter number*** should be completed, either by the screening site or by the Imaging facility that has been designated by Sage with enrollment capabilities. The patient’s consent is valid for 12 months. The mammogram/ultrasound date should be recorded as the visit date, and under the “mammogram ordered or done”, or “breast ultrasound ordered or done” questions, what imaging was provided should be checked. A new Sage Imaging Summary Form needs to be completed (for each imaging service) and sent to Sage (by the Imaging provider).

Imaging: Screening mammograms

The Sage Screening site notifies the mammography facility that a patient is a part of Sage either by sending the facility a Sage Mammogram Summary Form, with an encounter number or by providing the encounter number to the Imaging Facility when scheduling the patient’s mammogram. Patients should have had an office visit prior to their mammogram, and the mammogram should be completed within 4 months of the office visit.

Imaging: Additional mammographic views

When a patient's screening mammogram results are categorized as "assessment incomplete" additional mammographic views are often ordered. Please fill out **another** Sage Imaging Summary Form *using the same encounter number* as the initial screening mammogram for any additional diagnostic imaging: each imaging test requires a separate Sage Imaging Form. A patient may have a form for their Assessment Incomplete mammogram, a form for additional views (unilateral or bilateral), or breast ultrasound (unilateral or bilateral).

Imaging: Follow up mammograms

When a Sage screening mammogram result is an ACR category 3 (probably benign – short interval follow-up suggested), for follow-up breast imaging, a Sage enrollment form ***with a new encounter number*** should be completed, either by the screening site or by the Imaging facility that has been designated by Sage with enrollment capabilities. The patient's consent is valid for 12 months. The mammogram/ultrasound date should be recorded as the visit date, and under the "mammogram ordered or done," or "breast ultrasound ordered or done" questions, what imaging was provided should be checked. A new Sage Imaging Summary Form needs to be completed (for each imaging service) and sent to Sage (by the Imaging provider).

Imaging: Breast ultrasound

Sage will reimburse for breast ultrasounds when recommended by a clinician or radiologist for either immediate diagnostic workup (for an abnormal CBE or for an abnormal or "assessment incomplete" screening mammogram), or short term (3 – 6 month) follow-up of a screening abnormality.

Breast ultrasound for immediate diagnostic work-up

The facility performing the ultrasound will need to complete a Sage Imaging Summary Form for each patient receiving an ultrasound. The encounter number from the abnormal mammogram or CBE must be indicated on the form.

Short term (3 – 6 month) follow-up breast ultrasound

Follow-up/short term mammograms and/or breast ultrasound

The Sage Screening Program will reimburse for short term (i.e., 3 – 6 month) follow-up breast imaging mammogram, and/or breast ultrasound recommended to follow-up a "Probably Benign" (ACR category 3) finding. For follow-up breast imaging, a Sage enrollment form ***with a new encounter number*** should be completed, either by the screening site or by the Imaging facility that has been designated by Sage with enrollment capabilities. The patient's consent is valid for 12 months. The mammogram/ultrasound date should be recorded as the visit date, and under the "mammogram ordered or done", or "breast ultrasound ordered or done" questions, what imaging was provided should be checked. A new Sage Imaging Summary Form needs to be completed (for each imaging service) and sent to Sage (by the Imaging provider).

Other imaging services (X-rays, etc.)

Contact your Sage Follow-up Coordinator to determine if Sage can cover imaging services not listed on the approved CPT code list.

Lab services

Information for contracted reference laboratories

This section addresses the specific issues and paperwork related to cytology laboratories and pathologists that provide Sage Screening Program services, outlines procedures for providing Sage covered lab services, and gives instructions on completing the Pap Summary Form.

Patients are enrolled in the Sage program through a participating Sage Screening clinic. Reference labs cannot enroll Sage patients.

The patient must be enrolled through a Sage Screening site prior to any service. Lab service providers will receive a unique Sage encounter number from the screening site with the specimen. The encounter number is required on billing submission.

Pap tests

The Sage Screening site enrolls a patient in Sage and assigns an encounter number. The screening site does the exam, sends the Pap slide or specimen to the lab with the patient encounter number on a Sage Pap Summary Form (an alternative reporting format following the Bethesda terminology may be used with prior approval of Sage). The lab sends the usual Pap result to the clinic and also sends the result to the Sage Program on the Pap Summary Form (or actual report - if pre-approved).

The Sage Pap Summary Form should be completed and sent to Sage. The Specimen Type (1) Conventional, or (2) Liquid-based must be marked on the form or we cannot process the form or pay for the Pap test.

HPV

- The Sage Program reimburses for HPV DNA co-testing for patients ages 30 – 64 every 5 years.
- To triage an ASC-US Pap result when the Pap was covered by Sage. This can be done either reflexively from the original specimen if it was a liquid-based Pap, or by a return office visit (also covered) where the HPV sample is collected.
- Sage can also cover HPV as needed for surveillance after an abnormal cervical screening. Call the Sage Coordinator for more information.
- The HPV results should be noted on the Pap Summary form with the Pap results.

Pathology

The Sage Screening Program reimburses for the following services provided by pathologists:

1. Evaluation of abnormal screening pap tests
2. Surgical pathology associated with a cervical biopsy done by colposcopy
3. Endocervical (ECS) obtained by ECC or ECB
4. Evaluation of an aspirate obtained through a Fine Needle Aspiration of the breast
5. Pathology associated with outpatient breast biopsies
6. Pathology associated with endometrial biopsies.

Provider agreement requirements

In order to become a Sage provider, interested providers (such as screening sites, mammography facilities, reference laboratories, imaging centers, etc.) must complete an application and sign a provider agreement with Sage. The provider agreement enables providers to bill and be reimbursed directly by Sage. The information in this manual is considered part of the provider agreement.

Billing and reimbursement

This section covers billing and reimbursement from the Sage Programs.

Provider agreements

The Sage Programs can only reimburse organizations that have a current provider agreement with the Sage Program.

Billing: Basic requirements

1. Sage only accepts electronic claim submissions through clearinghouse.
2. Sage Programs is considered the payer of last resort, and other sources of payment such as patient insurance must be pursued prior to billing the Sage Program.
3. The provider agrees to accept Sage Program's allowable fee as full payment from all sources (including third-party coverage).
4. All Sage Program covered services are free to the patient once they are enrolled in the program. Contracted providers will not collect co-pays or deductibles.
5. The patient is never billed for services reimbursable under the Sage Program.
6. The patient is never charged a co-pay.
7. Claims and service forms must be received within 120 days from the date of service.
8. The patient's encounter number must appear on all billing submissions as patient's member ID.
9. A patient's primary payer payment must be submitted electronically on the secondary claim that is submitted to Sage.
10. Services not covered by Sage can be billed to the patient if they were made aware of their financial responsibility prior to services being rendered.
11. The patient's encounter number must appear on all billing submissions as patient's member ID.

Allowable procedure codes

- Sage Programs accepts CPT codes listed in the Sage Reimbursement Rates. For a list of Sage covered codes, visit the Sage Programs Billing web page.
    - Note: Refer to the Sage Program's reimbursement rate sheet (updated yearly) to determine billable CPT codes. Any CPT codes not relevant are not reimbursed.
- When billing for one component of mammography or ultrasound services (i.e., professional or technical), use the appropriate modifier.
- When billing for bilateral ultrasound services, the modifiers 50, LT and RT must be used to identify that ultrasounds were performed on both breasts.

- The provider determines the appropriate office visit level and procedures to charge.

Rates

- Federal law (Public Law 101-354) restricts Sage Programs reimbursement rates to the prevailing Medicare (CMS) rate for each allowable service (The Minnesota Colorectal Cancer Screening Program rates are based on the annual CMS Physician Fee Schedule (PFS), the CMS Clinical Laboratory Fee Schedule (CLFS), the CMS Hospital Schedule (OPPS), and the Ambulatory Surgical Center Payment Schedule (ASC).
    - Note: As a secondary payer, Sage will not pay more than the Medicare reimbursable rate for procedures. Regardless of the patient's primary payer indication for adjustments.
    - Rates change January 1 of each year. Rates may be updated June 30 of each year.

Setting up e-billing

- Providers need to arrange with a clearinghouse to transmit files to Utah Health Information Network (UHIN). The Sage Programs Payer Identification is MNDH1. If you do not find our payer ID on your clearinghouse's website, a customer request may be required. Please ask your clearinghouse to make this a priority. If there are any issues contact, UHIN Customer Service by phone 1-877-693-3071 or email at customersuccess@uhin.org.
- Some things to note regarding the e-claims:
    - Provide the Sage encounter number on the e-claim (837 file) as the Subscriber Identifier in HIPAA Loop ID 2100 and HIPAA Segment ID NM109.
    - Provide your NPI number on the e-claim (837 file).
    - We will provide remittance advice via the electronic forms (835 files), and you will receive a written remittance that we currently provide via the mail.
    - Since payment depends on the assurance that forms are received, we suggest that claims for service are generated after sufficient time has elapsed to allow for the receipt of these forms by the program (i.e. 2 weeks).

Submitting claims

- Sage accepts electronic claims and 837 file using Electronic Data Interchange (en.wikipedia.org/wiki/Electronic_Data_Interchange) to submit claim files.
- The designated MDH Sage clearinghouse is UHIN.
- Sage Program accepts electronic claim submission on UB-04, CMS-1450, and CMS-1500 forms. The following items must be included:
    - Federal Tax ID # of the organization to be paid
    - Organization or Clinic NPI numbers The NPI Sage uses is found on:
    - UB-04, CMS-1450, line 56

- CMS-1500, line 33A
- Name of the organization to be paid
- Address of organization to be paid
- Date of service
- Sage Program encounter number
- Patient's Name
- CPT Code (including a modifier, if applicable)
- Charge for services provided
- Amount Paid by Insurance (per CPT Code), with an explanation of benefits (EOB's) attached

Patients with insurance

- Providers are responsible for obtaining a patient's primary insurance information, if applicable.
- If a claim denies for "Patient has primary insurance. Re-bill with EOB information", the provider must attempt to collect that primary payer information from patient or payer portals. If it is found that the patient does not have primary insurance, reach out to Sage Billing Staff to have claim reprocessed.
- Insurance must be billed prior to billing the Sage Programs.
- The provider must supply the explanation of benefits (EOB) information in the 837 files.
- If insurance pays more than the Sage Program's allowable rate, Sage Programs will not pay more or less, and the patient is not billed for any portion remaining (remaining portion must be written off).
- HSAs are an account with an IRS status for individuals who have high-deductible insurance plans. These are not considered a third-party payer and should not be used to reimburse claims in advance of submission to Sage.

Payment

- Claims are processed every week. Electronic claims are processed in one week and the following week paper claims are processed. Electronic remits are sent out bi-weekly where paper remits are sent out weekly.
- Electronic transmission of payment should be received shortly after the Sage payment process is completed.
- The electronic transmission may contain payments from other programs processed through the State of Minnesota. The payment information can be found at Minnesota Supplier Portal (mn.gov/supplier).
- Sage Program payments are clearly marked and contain a Sage payment number as a reference.

Credits

In situations in which an insurance payment is received after Sage has paid, or payment has been made to your organization in error, reimbursement to the Sage Program can be made by issuing a check payable to: Treasurer – State of Minnesota.

Attach a list to the check that includes the **patient's name**, **encounter number**, **date of service**, **CPT code**, and the **amount received on each CPT code**. Attach the EOBs to the list or highlight the items to be reimbursed on the remittance advice, attach the explanation of benefits to the remittance summary. After the Sage Program processes this information, the check will be forwarded to MDH Financial Services for deposit.

Note: As a secondary payer, Sage will not pay more than the Sage reimbursable rate, which is based on the Medicare allowable, for procedures. Regardless of the patient's primary payer indication for adjustments. If the patient's primary insurance made a payment after Sage made a payment, Sage must be reimbursed any amount that is over the reimbursable rate Sage pays, regardless of patient responsibility as indicated by their primary insurance. The remaining total after refund to Sage must be written off. The refund amount must be for the allowable amount during the year in which services were rendered.

The check and all documentation should be mailed to:

Sage Programs
Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882

Remittance

A remittance advice detailing all claims processed is sent:

- As an electronic ANSI 835 file when all items on a claim have been either paid or denied. Items held in suspense until form information is received are listed on a paper remittance mailed after the claim is processed.
- In paper form as the Sage Remittance Advice that is mailed every time Sage makes a payment. When a paper claim payment is made, a paper remit is the only remit that will be sent as confirmation of payment on claims.
- For paper or electronic claim items and electronic claim items that are neither paid or denied (i.e. held in a status of "WAIT" pending submission of forms), a paper Sage Remittance Advice is sent to the organization billing contact. The remittance advice lists all claims on file with the Sage Programs.

Frequent error messages

- **Timely filing has expired**
  - Issue: The date of service on the claim is over our timely filing limit or we have not received patient paperwork within our timely filing limit.

- Solution: Provider billings will have to write off the balance for timely filing. Call Sage with questions on timely billing requirements.

- **The patient has primary insurance. Re-bill with EOB information**
  - Issue: Patient reported that they have primary insurance on enrollment form and therefore our records reflect that the patient has primary insurance.
  - Solution: Confirm primary insurance with patient and bill the patient's primary insurance. Submit secondary claim to the Sage Program that contains EOB from the patient's primary insurance.
  - After confirming with patient, it is identified that patient does not have primary insurance, please contact Sage Billing to report and update the patient's insurance information.
- **Mammogram or breast ultrasound results needed**
  - Issue: The charges are not being paid at the time of the remittance because the form or results that validate the corresponding service have not been received.
  - Solution: Submit a completed Imaging Summary Form or dictated report for the type of imaging you are billing. Make sure the patient's encounter number is on the Imaging Summary Form or dictated report and matches the encounter number and date of service billed. Resubmit claims if necessary.
- **Pap or HPV results needed**
  - Issue: The charges are not being paid at the time of the remittance because the forms or results that validate the corresponding service has not been received.
  - Solution: Submit a completed Pap Summary Form or other approved Pap report. Make sure the patient's encounter number is on the Pap Summary Form or dictated report and matches the encounter number and date of service billed. Resubmit claims if necessary.
- **Billed date of service (DOS) different from DOS reported**
  - Issue: Sage Program has received results for this service, but the DOS on the forms does not match the DOS billed.
  - Solution: Verify the encounter number and DOS and send dictated reports for review.
- **Encounter number is invalid**
  - Issue: The encounter number billed is not a valid site code to one of our Sage sites, does not meet our format or is not the correct encounter number assigned by the clinic for the DOS.
  - Solution: Check the claim to see if a valid Sage encounter number is assigned, encounter number starts with three alpha letters followed by three to six numbers and check with clinic registration to obtain correct encounter number for DOS.

- **Pap not covered by Sage per pap periodicity**
  - Issue: Pap test not covered per CDC Pap periodicity policy.
  - Solution: Check to see if the patient is due for a Pap. Sage pays for a Pap test every three years or if the patient is new to your clinic.
- **Service billed does not match service reported on the form**
  - Issue: Sage Program has received results for this service, but the DOS on the forms does not match the DOS billed.
  - Solution: Verify the encounter number and DOS and send dictated reports for review.
- **Charge code (CPT) is not payable by Sage**
  - Issue: Payment was disallowed as this was not a Sage allowable service.
  - Solution: If the service was done during the patient Sage visit, the charges may or may not be billed to the patient. See section “Billing: Basic Requirements.”
  - If charges are billed with the same DOS when the patient had a diagnostic breast procedure ex: breast biopsy, FNA, simple cyst aspiration or with a colonoscopy. Sage considers these charge denials as bundled services and balance should be written off.
- **Patients' primary insurance payments exceed the amount allowed by Sage**
  - Issue: Amount of payment from the patient's primary insurance is more than the Medicare rate Sage pays.
  - Solution: The remainder of the balance must be written off.
- **Service already paid under a different CPT code**
  - Issue: Another code has been submitted for the same service and DOS
  - Solution: Call Sage Billing to review the claim if this was an error.
- **Visit form not found for this encounter number**
  - Issue: The Sage Program has not received a copy of the visit form matching the encounter number being billed.
  - Solution: Check that the correct encounter number was billed by reviewing a copy of the visit form. If the encounter number is incorrect on the remittance advice, re-bill with the correct encounter number. If the encounter number is correct on the remittance advice, forward a copy of the appropriate visit form and the Sage enrollment form to the Sage Program. Make sure that all required information is filled out on the visit form.

Data privacy

The Sage Screening Program complies with state and federal privacy laws. See 45 C.F.R. §164.508(c)(1) and MN Stat. §13.05, subd. 4(d), 144.335, subd. 3a (2002).