

**SAGE BREAST DIAGNOSTIC  
PROCEDURES / SAGE SCOPES  
BILLING RULES**

**10/05/2010**

## General Rules

### **M# authorization:**

Authorization for breast diagnostic procedures must be obtained by calling 651-201-5600  
All Sage Program breast diagnostic procedure claims must have a Sage M# on the claim

- Sage recommends placing the M# in field 60 of the CMS 1450 (UB04)
- Sage recommends placing the M# in field 23 of the CMS 1500

Facilities must use the correct CMS claim form to bill for the service provided

- CMS 1500 for professional services (physician services)
- CMS 1450 (UB04) for facility charges

*Example: A hospital-based clinic billing an office visit (99201) done in the outpatient setting would result in a payment on the CMS1500 claim for the physician's services and another payment on a separate UB04 claim for the facility use.*

### **Payment Amounts:**

Sage patients will not be subject to paying any coinsurance amount. Sage payment will be accepted as payment in full.

Sage payments are based on Centers for Medicaid and Medicare Services (CMS) payments for services according to the following payment systems:

- Physician Fee Schedule (PFS) for professional services [*services billed on CMS1500*]. The CMS PFS is found on the Wisconsin Physician Services (WPS) website at: [http://www.wpsmedicare.com/part\\_b/fees/physician\\_fee\\_schedule/](http://www.wpsmedicare.com/part_b/fees/physician_fee_schedule/)
- Outpatient Prospective Payment System (OPPS) for hospital facility fees [*services billed on UB04*]. Sage cannot make any adjustments to the OPPS payment for special types of hospitals (i.e. Critical Access Hospitals, or sole Community Hospitals) as Sage does not have access to the CMS cost reports for individual facilities. The CMS OPPS is found in Appendix B on the CMS website at: <http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>
- CMS Ambulatory Surgical Center Fee Schedule (ASCFS) for Ambulatory Surgical Center (ASC) facility fees [*services billed on UB04*]. The ASC Fee Schedule is found in Appendix AA on the CMS website at: [http://www.cms.gov/ASCPayment/11\\_Addenda\\_Updates.asp#TopOfPage](http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage)
- Clinical Laboratory Fee Schedule (CLFS) for laboratory services [*billed on either CMS1500 or UB04*]. The CLFS can be found on the CMS website at: [http://www.cms.gov/ClinicalLabFeeSched/02\\_clinlab.asp#TopOfPage](http://www.cms.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage)

Appeals for a denied claim or non-payment for a billed service may be requested.

## **Billing/Payment Rules for Professional Services**

(physician or anesthesia services)

### **Claim form CMS1500:**

Claims must be submitted on CMS 1500 until Sage is capable of receiving electronic claims (837).

### **Place of Service (POS):**

Field 24b must indicate your POS code; 11- Office, 22 – Hospital, or 24 – Ambulatory Surgical Center. Other codes such as Indian Health Service settings 05, 06 or Tribal facilities code 07 will be considered equivalents to code 11 for Sage.

**Place of Service (POS) based Sage reimbursement:**

- for 11 will be the CMS PFS non-facility payment rate (full payment),
- for 22 will be CMS PFS facility payment rate (reduced payment),
- for 24 will be CMS PFS facility payment rate (reduced payment).

Note: Sage will use the CMS PFS rates established for Jan. 1 each year, subject to adjustment July 1 each year based on any subsequent changes to the CMS PFS at that time.

**Type of Service:**

Sage requires, and will only recognize, CPT or HCPCS codes for the services provided. All appropriate modifiers must be used.

- On CMS1500- Field 24d, enter the CPT or HCPCS code(s) and modifiers (if applicable) in effect on the date of service.

**Specific rules for Anesthesia Services**

**CMS 1500:**

These are services billed on a CMS1500 with a Place of Service (POS - field 24b) code of 22 or 24.

**Coding:**

Use the specific CPT American Society of Anesthesiology (ASA) anesthesia codes with the appropriate anesthesia modifier.

- Sage Program acceptable ASA CPT codes for anesthesia services:
  - 00400 – 3 base units
- SageScopes Program acceptable ASA CPT codes for anesthesia services:
  - 00810 – 5 base units

To properly identify the exact nature of the service provided, use the following modifiers:

<b>Anesthesia Modifiers</b>	
AA	Anesthesia services performed personally by anesthesiologist
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA service with medical direction by an anesthesiologist
QY	Anesthesiologist medically directs one CRNA
QZ	CRNA service without medical direction by an anesthesiologist

**Anesthesia Payment:**

Anesthesia payment is per CPT code and anesthesia modifier based on the following formulae:

Anesthesia personally provided by a Physician - modifier AA:

- [#Base Units\* + (Time/15)] x current CMS conversion factor
- Only one payment allowed for this type of anesthesia service

Anesthesia personally provided by a CRNA - modifier QZ:

- [#Base Units\* + (Time/15)] x current CMS conversion factor
- Only one payment allowed for this type of anesthesia service

Medical direction of Anesthesia services by a Physician - modifier QY

- 50% of [#Base Units\* + (Time/15)] x conversion factor
- This type of anesthesia service can be paid in addition to e (below)

Medical direction of multiple Anesthesia services by a Physician - modifier QK

- 50% of [#Base Units\* + (Time/15)] x conversion factor
- This type of anesthesia service can be paid in addition to e (below)

Anesthesia services provided by a CRNA under medical direction by a Physician - modifier QX:

- 50% of [#Base Units\* + (Time/15)] x conversion factor
- Can be paid in addition to c or d (above)

\* # base units are assigned by CPT code (see 3a and b below)

2. Time units/15 is truncated at one decimal place. Example: 62/15 = 4.1
3. Current CMS anesthesia rate (conversion factor):
  - <http://www.cms.hhs.gov/center/anesth.asp>
4. Current Base Units:
  - <http://www.cms.hhs.gov/center/anesth.asp>
5. Sage will not reimburse a surgeon for supervision of anesthesia services provided by a CRNA, anesthesia assistant, intern, or resident.

**Billing/Payment Rules for Facility Fees** (Hospital or Ambulatory Surgical Centers)

**Claim form CMS1450 (UB04):**

Hospitals and Ambulatory Surgical Centers must submit their claims on the CMS1450 (UB04) claim form until Sage is capable of receiving electronic claims (837).

**Type of Bill (TOB):**

This four-digit alphanumeric code gives three specific pieces of information after a leading zero. Sage will ignore the leading zero. The second digit identifies the type of facility. The third digit classifies the type of care. Sage will ignore the fourth digit.

Code Structure\*:2nd Digit-Type of Facility

1 Hospital

7 Clinic

8 Special facility or hospital ASC surgery

3rd Digit-Bill Classification (Except Clinics and Special Facilities)

3 Outpatient

3rd Digit-Classification (Clinics Only)

1 Rural Health Clinic (RHC)

3 Free Standing Provider-Based Federally Qualified Health Center (FQHC)

9 OTHER

3rd Digit-Classification (Special Facilities Only)

3 Ambulatory Surgical Center Services to Hospital  
Outpatients  
5 Critical Access Hospital

\*based on the Medicare Claims Processing Manual, Chapter 25, section 75

**Type of Bill (TOB) based Sage reimbursement:**

- for 013X will be the CMS OPPS payment,
- for 071X, 073X, 079X, 085X will be treated the same as 013X and paid the unadjusted CMS OPPS payment,
- for 083X it will be the unadjusted CMS Ambulatory Surgical Center Fee Schedule payment rate.

Note: Note: Sage will use the CMS OPPS rates established for Jan. 1 each year, subject to adjustment July 1 based on any subsequent changes to the CMS OPPS.

CMS OPPS payment will be the unadjusted Addendum B amount

- Sage will not adjust payments to Hospitals (013X and equivalents) based on the CBSA wage index for the facility.
- Sage will not adjust payments to Ambulatory Surgical Centers (083X) based on the CBSA wage index for the facility.
- Sage cannot adjust payments to Critical Access Hospitals (085X) and must treat them the same as hospitals generally (013X) – Sage has no access to Facility Cost Reports to base such adjustments.
- Sage cannot make Hold Harmless Adjustments (TOP) for Sole Community Hospitals.
- Sage cannot make Outlier Charge Adjustments - Sage has no access to Facility Cost Reports to base such adjustments.

**Type of Service:**

Sage requires, and will only recognize, CPT or HCPCS codes for the services provided.

- On UB04- Field 44, enter the CPT or HCPCS code(s). All appropriate modifiers must be used.

CPT or HCPCS codes will be grouped according to Ambulatory Payment Classification (APC) for payment by Sage.

**Facility Payment for Hospital Outpatient services**

1. Each CPT code is paid according to the OPPS APC payment rules subject to packaging. Packaging is dependent on the Status Indicator for each APC code.
  - a. S – Represents significant APC procedures that are not subject to multiple procedural discounting.
  - b. T – Represents significant APC procedures that are subject to multiple procedural discounting. The primary procedure is paid at 100% of the APC payment rate and subsequent procedures are paid at 50% of the APC rate.
  - c. V – Represents medical visits billed on a per-visit basis
  - d. X – Represents ancillary services billed on a unit basis
  - e. N – Represents service that is packaged into payment for other services.  
Therefore, there is no separate payment for these services.
2. Payment is subject to discounting by 50% if:

- a. if a procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is provided.
- b. if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.

## **Billing/Payment Rules for Laboratory Services** (labs)

### **Claim form CMS1500 or UB04:**

Claims must be submitted on CMS 1500 or UB04 until Sage is capable of receiving electronic claims (837).

### **CLFS based Sage reimbursement:**

Note: Sage will use the CMS CLFS rates established for Jan. 1 each year, subject to adjustment July 1 each year based on any subsequent changes to the CMS CLFS.

### **Type of Service:**

Sage requires, and will only recognize, CPT or HCPCS codes for the services provided. All appropriate modifiers must be used.

- On CMS1500- Field 24d, enter the CPT or HCPCS code(s) and modifiers (if applicable) in effect on the date of service.
- On UB04- Field 44, enter the CPT or HCPCS code(s) and modifiers (if applicable) in effect on the date of service.

## **Other General Billing/Payment Rules**

### **Procedures subject to multiple procedure discounts:**

Procedures with a OPPS status indicator (SI) of T are subject to multiple procedure discounts.

- Highest reimbursement procedure is paid at 100%,
- subsequent procedures in the same session are paid at 50%

### **Procedures for which payment may be packaged into payment for other procedures.**

Procedures with OPPS status indicator (SI) of N are not separately paid (payment assumed to be covered by another procedure code).

### **Procedures for which payment is bundled into payment for other procedures**

Procedures indicated by the National Correct Coding Initiative (NCCI) edit for bundled services are not separately paid (payment assumed to be covered by another procedure code).

### **Procedures terminated prior to completion.**

Terminated procedures are reimbursed as follows:

- Use modifier -73 if anesthesia is planned and the patient has been prepped and taken to procedure room, but the procedure was terminated before anesthesia started. Paid at 50%.
- Use modifier -52 if anesthesia is not planned and the patient has been prepped and taken to procedure room, but the procedure was terminated. Paid at 50%
- Use modifier -74 if anesthesia is planned and the patient has been prepped and taken to procedure room, but the procedure was terminated after anesthesia or the procedure has started. Paid at 100%.

### **Multiple breast ultrasound procedures**

When billing breast ultrasound procedures (76645) performed on both breasts in a session there is only one payment.

### ***[Note for Sage Processing of Claims]***

#### **For all Codes with –TC or -26 modifiers:**

For UB04 claims-

- No modifier
  - from a 13 or 83 location without the modifier assume the 13 or 83 payment if it exists in the rate table if it doesn't there is no payment.
- -26 modifier
  - not acceptable on the UB04 claim form
- -TC modifier
  - from a 13 or 83 location will be paid if the 13 or 83 payment exists in the rate table, if not there is no payment. Do NOT use the –TC payment.
- When selecting payment amount do NOT reduce to a charge amount that is less than the OPPS payment.

For CMS1500 claims-

- No modifier
  - From a 11, 22, or 24 location pay the global fee
- -26 modifier
  - From a 11, 22, or 24 location pay the -26 fee
- -TC modifier
  - From a 11, 22, or 24 location pay the -TC fee
- When selecting payment amount reduce the PFS or CLFS payment amount to the charge amount if the charge amount is less than the PFS or CLFS payment amount.

