CMS, X-Rays, and the "FX" Modifier

These Q & A's recently appeared on Codingline.

BY HARRY GOLDSMITH, DPM

CR vs DR X-Ray Systems

Query: *"Is there a modifier to let CMS know we are using a CR system vs. an analog or DR system? We are adjusting much of our x-ray fees. Are we being penalized for not using a modifier that tells them we are digital versus analog? Would it be wise, sooner rather than later, to upgrade our system to DR?"*

Response: I don't think CMS could have done a worse job confusing practitioners with x-ray units. First, the final rule requiring the shift from analog (penalties) to digital was published less than two months before implementation. Second, CMS made a distinction between two types of digital x-rays capturing images: CR (computed radiology) and DR (direct radiology) warning of future penalties. Third, the penalty of using an analog x-ray unit after January 1, 2017 was to be applied to the "technical" component allowance and not to include the "professional" component. And, lastly, it was up to the practitioner with the analog unit to "inform" CMS that they should be penalized with the application of the "FX" modifier to their claimed x-ray codes.

CMS should have provided more time for doctors to transition (purchase) to digital units. That train has left the station. The other thing CMS should have done was not have doctors with analog units apply the "FX" modifier to their claims, but have those with digital units apply it to theirs. Not having the modifier would have alerted the MAC when processing claims to penalize the "analog" practitioners.

Reference (CMS)—"Beginning January 1, 2017, claims for x-rays using film must include modifier FX. A payment reduction of 20 percent applies to the technical component (and the technical component of the global fee) for x-ray services furnished using film for which payment is made under the Medicare Physician Fee Schedule (MPFS). CR-based X-rays will be reduced by 7% from 2018 to 2022 and then increase to a 10% reduction in 2023 and beyond."

Referral for Supplying DME

Query: *"If a patient was seen by his/her primary care physician, and told to come to our office to be fitted and dispensed a pneumatic walking boot (L4361), how would we go about billing this to our DMAC (or the patient's insurance company) since he/she wasn't/isn't technically a patient in our practice?"*

Response: It is very important that you understand that if the person has Medicare, your special designation as a "physician-supplier" under Medicare limits your dispensing DME, therapeutic shoes, and supplies to your patients only. You cannot see patients referred for DME from other offices or "walk-ins" for the purpose of dispensing items like AFOs or walking boots. In that scenario, you would be no different than a commercial medical supply house or pharmacy. You certainly can request a change in your supplier designation to "commercial", but keep in mind, in that case, you will need to be accredited and obtain a surety bond just like other commercial suppliers.

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Obviously, if the referred person is a current patient or becomes a patient that you examine and treat, their status changes to that of a patient in your office…and you can dispense items as a "physician-supplier".

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If this is a non-Medicare "patient", the rules regarding your ability to dispense are specific to the payer and plans. You absolutely need to qualify your ability to dispense DME and supplies not only to "patients" referred to you for the purpose of your dispensing items, but also your own patients. For example, if the plan has a contract with a local supplier, the patient may be restricted to "pick up" orthoses or supplies with a prescription. Check with the individual payer.

You might want to speak with the patient's primary care physician, and inform him/her regarding your ability to dispense items.

Scheduled Return for Routine Foot Care & Documentation

Query: *"If you have patients returning to your office or you are seeing them in a facility such as a nursing home for "routine foot care", do you have to repeat your examination findings in your documentation the next time you see them if nothing has changed and they still qualify as "at risk"? Obviously, if something changes from the previous visit, I expect to document that, but do I have to otherwise repeat previous findings in order to qualify the patient during the current encounter?"*

Response: This is a common question. Medicare requires a detailed, accurate record describing the patient's current findings. But to your question, no, you are not obligated to write out the same description of your findings again. You are, however, obligated to provide the details even if they are referenced to a previous note along with the inclusion of a line like, "There have been no changes in the patient's history, vascular, neurological examination findings from [add a previous medical record entry date]." You might, however, want to document both the dermatological examination specific to routine foot care requirements and your treatment.

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If you do decide to reference a previous note with details that have not changed, be sure on "request for medical records" to send in not only the date of service records requested, but also the referenced medical records with the details.

Having said that, there are some who feel that by the time you enter this "documentation shortcut", with a good template (either in your EHR or on paper), you can fill in the contemporaneous findings du jour just as quickly.

Aspiration of Ganglion Cyst

Query: *"I have been told that CPT 10021 (fine needle aspiration; without imaging guidance) and CPT 20612 (aspiration and/or injection of ganglion cyst(s) any location) can and should be billed together when aspirating a ganglion. This seems a little fishy to me. Can you please describe the difference between CPT 10021 and CPT 20612, and as well explain when to use CPT 10021? The value of CPT 10021 is twice that of CPT 20612."*

Response: You have been told wrong. First, both are aspiration codes—why in the world would anyone think you would be allowed to be reimbursed for two types of aspiration on a single ganglion cyst? Secondly, the person passing on this information appears not to appreciate or understand not only the rules of coding, but definitional differences. Third, when choosing codes to bill, you do not decide based on financial advantage to you, but based on the most specific, accurate code describing the service or procedure you performed.

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Let's look at the codes themselves, since that plays a very big part in answering your question.

Scenarios for use of CPT 10021, by way of example, describe pre-aspiration presence of 1) a palpable breast mass and 2) a thyroid nodule. The intra-op procedure example reads, "Inject local anesthesia (optional). Insert a needle with attached syringe inserted into mass. Perform numerous short up-and-down excursions with negative pressure applied to syringe. Withdraw needle and express material onto slides or into fixative" for analysis by the lab.

The CPT 20612, on the other hand, description is very specific: aspiration and/or injection of ganglion cyst(s) any location. Most doctors I am aware of aspirate ganglions to reduce the cystic content and/or to therapeutically insert steroid.

You said this patient had a ganglion that you aspirated. Between the two codes, which code specifically describes what you have in front of you and what you did?

I would be interested in hearing for what condition/pathology on the foot or ankle someone would typically need to perform a fine-needle

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aspiration on. By the way, the fact that you already use a "fine" needle (25, 27 gauge) for most of your injections does not qualify the code.

Codingline 2017

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.