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, if the person has Medicare, that 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.

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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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.

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 imagining 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

If this is a non-Medicare “patient”, the rules regarding your ability to dispense are specific to the payer and plans.
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.

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**The CPT 20612 description is very specific:** aspiration and/or injection of ganglion cyst(s) any location.

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