healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Radiological Chest Examination		
Policy Number:	PO-RE-084v2		
Effective Date:	12/01/2020	**Last Approval Date:**	6/30/2026

I. Policy Description

Healthfirst will no longer reimburse for chest X-Ray procedures with service codes 71045 and 71046 unless there is a diagnosis of pertinent signs, symptoms, or diseases. This policy aligns with the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) and the American College of Radiology (ACR), which state that chest X-rays should not be performed for screening purposes in the absence of relevant symptoms, signs, or diseases.

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicaid Managed Care (MMC)	• Qualified Health Plan (QHP)
• Medicare Advantage HMO	• Personal Wellness Plan (HARP
• Medicare PPO	

Reimbursement Guidelines

1. Reimbursement Eligibility:
    a. Chest X-Rays with service codes 71045 and 71046 will be eligible for reimbursement if there is an accompanying diagnosis of pertinent signs, symptoms, or diseases.
    b. The diagnosis must be clearly documented in the medical records and submitted with the claim for reimbursement.

2. Claims Process:
    a. Claims for reimbursement of chest X-Ray procedures (71045 and 71046) without a diagnosis of pertinent signs, symptoms, or diseases will be denied.
    b. Providers are responsible for ensuring that the appropriate diagnosis codes are accurately reported on the claim form.

3. Documentation Requirements:
    a. The medical documentation must clearly indicate the signs, symptoms, or diseases that warrant the chest X-Ray.

b. Diagnostic codes corresponding to the pertinent signs, symptoms, or diseases must be included in the medical records and submitted with the claim for reimbursement.

Note: It is the responsibility of healthcare providers to stay updated with the latest CMS guidelines and ACR recommendations regarding chest X-Ray reimbursements.

Adjudication and Appeal Process

1. Reimbursement for Radiological Chest Examination services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, "Billing & Claims Processing".*

II. Applicable Codes

Code	Description	Comment
71045	Radiologic examination, chest; single view	
71046	Radiologic examination, chest; 2 views	
71047	Radiologic examination, chest; 3 views	
71048	Radiologic examination, chest; 4 or more views	

III. Definitions

Term	Meaning

ACR	American College of Radiology

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

V. Reference Materials

Billing and Coding: Chest X-Ray Policy (A57497)
ACR–SPR–STR Practice Parameter For The Performance Of Chest Radiography
Routine Chest Imaging

VI. Revision History

Revision Date	Summary of Changes
6/30/2026	**Annual Review:** Policy reviewed as part of the annual review process; no substantive changes to policy intent. **Adjudication Section:** Updated the adjudication section to include standard organizational boilerplate language and messaging. **Line of Business Section:** Updated the Line of Business (LOB) section to align with the organization's standard LOB language and format.

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding

edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.