healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Chest X-Rays for Lung Cancer Screening		
Policy Number:	PO-RE-085v2		
Effective Date:	02/01/2022	**Last Approval Date:**	6/30/2026

I. Policy Description

This policy outlines the reimbursement guidelines for chest X-ray procedures performed for the sole purpose of lung cancer screening or assessing nicotine use/dependence. Healthfirst will no longer reimburse providers for chest X-ray procedures (71045-71048) when the only reported diagnosis is for lung cancer screening or nicotine use/dependence.

In alignment with the recommendations of the American College of Chest Physicians and the American College of Radiology, chest X-rays are not considered effective for the purpose of lung cancer screening in asymptomatic patients. Similarly, the use of chest X-rays to address nicotine use/dependence is not supported as an effective diagnostic or screening tool.

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	

Policy Scope

Healthfirst will not reimburse healthcare providers for chest X-ray procedures when the reported diagnosis is solely for lung cancer screening or nicotine use/dependence. Claims submitted with these diagnoses will be subject to denial under this policy.

Reimbursement Guidelines:

1. Claims for chest X-ray procedures with the only reported diagnosis of lung cancer screening or nicotine use/dependence will be reviewed by Healthfirst's claims adjudication team. If the

submitted claim meets the criteria outlined in this policy, it will be denied in accordance with the policy guidelines.

2. Providers will receive notification of claim denials in cases where the chest X-ray procedure is performed solely for lung cancer screening or nicotine use/dependence. The denial notice will include reference to this policy and the specific reason for denial.

Adjudication and Appeal Process

1. Reimbursement for Chest X-Rays 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.

5. 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

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Diagnosis and Management of Lung Cancer: American College Physicians Evidence-Based Clinical Practice Guidelines
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.