healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Radiological Chest Examination		
Policy Number:	PO-RE-084v1		
Effective Date:	12/01/2020	**Last Approval Date:**	12/18/2023

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.

Policy Scope

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. 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.

Reimbursement Guidelines:

1. 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.

2. Appeals Process:

a. Providers may request a reconsideration or appeal in cases where they believe the denial of reimbursement was in error.
b. Appeals must include additional supporting documentation justifying the medical necessity of the chest X-Ray procedure.

This reimbursement policy is subject to periodic review and may be revised or updated in accordance with changes in CMS policies or ACR guidelines.

Please consult the Healthfirst Provider Manual or contact the Healthfirst Provider Services for any further clarification or assistance.

In Scope Lines of Business:

Medicaid, Child Health Plus, Personal Wellness Plan (HARP), Essential Plans, Leaf and Leaf Premier Plans, Pro Plus EPO Plans, Signature PPO, Signature HMO, 65 Plus Plan (HMO), Increased Benefits Plan (HMO), Life Improvement Plan (HMO D-SNP), CompleteCare (HMO D-SNP), Connection Plan (HMO D-SNP), Senior Health Partners (MLTC)

II. Applicable Codes

Code	Description	Comment
71045	Radiologic examination, chest; single view	
71046	Radiologic examination, chest; 2 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

VI. Revision History

Revision Date	Summary of Changes

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.