Priority Health	BILLING POLICY No. 212
CHEST X-RAYS AND ACR APPROPRIATENESS CRITERIA	
Date of origin: 10/26	**Review dates: NA**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation for Chest X-rays and provides billing guidance for facilities, ensuring claims are processed according to contractual agreements and industry standards.

In the inpatient hospital setting, CXR is eligible for reimbursement when supported by a treating physician's signed written order and documented interpretation and report in the patient's medical record. When a physician issues a signed written order for one (1) CXR with multiple views, only one charge is eligible for reimbursement. Unbundling CXR into component views is not separately reimbursable. Chest X-rays views include, but are not limited to, the following:

- Single view
- 2 views
- 3 views
- 4 or more views

DEFINITIONS

The American College of Radiology (ACR) Appropriateness Criteria: Evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision.

Chest X-Ray: The use of ionizing radiation in the form of X-rays to generate images of the chest. Chest X-rays can detect and assist in the diagnosing, management, and staging of various conditions.

Therapeutic Radiopharmaceuticals: Radioactive agents that are administered in large doses to treat certain medical problems or diseases.

Contrast Agents: Dyes or other substances that are used in a variety of radiologic techniques to enhance visibility and assist in diagnosis.

MEDICAL POLICY

- Priority Health's **Medical Necessity Determination** policy (No. 91447, effective 09/01/2026)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

See below a table for Chest X-ray billing. This is not the complete CPT code set, but a partial list for reference. Unlike other CPT families, the chest X-ray codes aren't based on diagnosis or clinical indication. They are based purely on how many radiographic projections were actually captured, for example a posteroanterior (PA) and lateral pair, is billed as 71046 not as two units of 71045.

CPT Code	Description	Typical Use Case
71045	Chest X-ray, single view	Single AP or PA (often portable AP)
71046	Chest X-ray, two views	PA and lateral
71047	Chest X-ray, three views	PA + lateral + additional projection (e.g., apical/lordotic)
71078	Chest X-ray, four or more views	PA + lateral + obliques and/or additional projections

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation. The most common modifiers used for Chest X-ray claims are mentioned in the following:

Modifier -26 (Professional Component): Used when billing only for the radiologist's interpretation and report, typically when the equipment is owned by a hospital or separate facility.

Modifier -TC (Technical Component): Used only when you are billing for the technical side of the equipment, technologist time, and supplies without interpretation.

Modifier 52 - Reduced Services: If the service provided was less extensive than described by the CPT code, such as fewer views than typically required, this modifier might be used to indicate that the service was reduced.

Modifier 76 - Repeat Procedure by Same Physician: If the same physician needs to perform the chest x-ray again on the same day for the same patient, this modifier would be used to indicate that the procedure was repeated.

Modifier 77 - Repeat Procedure by Another Physician: Similar to Modifier 76 but used when a different physician performs the repeat procedure on the same day.

Modifier 59 - Distinct Procedural Service: This modifier is used to indicate that a procedure or service was distinct or independent from other services performed on the same day. It might be applicable if the x-ray was performed in conjunction with other diagnostic procedures.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Diagnosis

Priority Health use LCD A57497 article as a reference for ICD-10 Codes that do not support medical necessity in combination with specific routine encounters included in the list below. Article - Billing and Coding: Chest X-Ray Policy (A57497)

ICD10 Code	Description	Source
D64.9	Anemia, unspecified	CMS Article ID: A57497

I70.90	Unspecified atherosclerosis	CMS Article ID: A57497
M06.9	Rheumatoid arthritis, unspecified	CMS Article ID: A57497
M25.559	Pain in unspecified hip	CMS Article ID: A57497
M54.50	Low back pain, unspecified	CMS Article ID: A57497
M54.51	Vertebrogenic low back pain	CMS Article ID: A57497
M54.59	Other low back pain	CMS Article ID: A57497
N39.0	Urinary tract infection, site not specified	CMS Article ID: A57497
R41.0	Disorientation, unspecified	CMS Article ID: A57497
R41.82	Altered mental status, unspecified	CMS Article ID: A57497
R51.0	Headache with orthostatic component, not elsewhere classified	CMS Article ID: A57497
R51.9	Headache, unspecified	CMS Article ID: A57497
R52	Pain, unspecified	CMS Article ID: A57497
R68.89	Other general symptoms and signs	CMS Article ID: A57497
S09.90XA	Unspecified injury of head, initial encounter	CMS Article ID: A57497
T14.90XA	Injury, unspecified, initial encounter	CMS Article ID: A57497
Z01.810	Encounter for preprocedural cardiovascular examination	CMS Article ID: A57497
Z01.818	Encounter for other preprocedural examination	CMS Article ID: A57497
Z04.3	Encounter for examination and observation following other accident	CMS Article ID: A57497
Z98.890	Other specified postprocedural states	CMS Article ID: A57497
Additional ICD-10 "Z" codes that are part of the ICD-10-CM system and cover routine examinations.		
Z00.0	General medical examination	Routine encounter
Z00.01	Encounter for general adult medical examination with abnormal findings	Routine encounter
Z00.6	Encounter for examination for normal comparison and control in clinical research program	Routine encounter
Z00.8	Encounter for other general examination	Routine encounter
Z01.811	Encounter for preprocedural respiratory examination	Routine encounter
Z02.0	Encounter for examination for admission to educational institution	Routine encounter
Z02.1	Encounter for pre-employment examination	Routine encounter
Z02.2	Encounter for examination for admission to residential institution	Routine encounter
Z02.3	Encounter for examination for recruitment to armed forces	Routine encounter
Z02.4	Encounter for examination for driving license	Routine encounter
Z02.5	Encounter for examination for participation in sport	Routine encounter
Z02.6	Encounter for examination for insurance purposes	Routine encounter
Z02.8	Encounter for other administrative examinations	Routine encounter

Z02.81	Encounter for pre-adoption examination	Routine encounter
Z02.83	Encounter for blood-alcohol and blood-drug test	Routine encounter
Z02.85	Encounter for examination for participation in extracurricular activities	Routine encounter
Z02.86	Encounter for examination for participation in work activities	Routine encounter
Z02.89	Encounter for other administrative examinations (more specific category under Z02.8)	Routine encounter
Z04.6	Encounter for general psychiatric examination, requested by authority	Routine encounter

Drugs and Supplies

Drugs and medical/surgical supplies used during the radiologic guidance procedure are considered Integral components of a diagnostic radiologic procedure are not reimbursable.
Unbundling drugs and medical/surgical supplies from the radiologic guidance procedure is not separately reimbursable.
Diagnostic radiopharmaceuticals and certain imaging agent(s) are an integral component to the diagnostic procedure. Unbundling imaging agent(s) from the diagnostic procedure is not separately reimbursable. Note: Therapeutic radiopharmaceuticals are eligible for reimbursement.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Multiple chest x-rays performed at separate sessions on the same day must be clearly documented in the patient's medical records to be considered for reimbursement. Documentation must include a physician signed written order and chest x-rays interpretation and report. Repeating chest x-rays due to provider technical errors are not reimbursable. The patient's medical record must support the interpretation and report as an independent reimbursable service.

Reimbursement specifics

Reimbursement may be divided into a technical component or TC (performing the Chest X-rays) and a professional component or PC (interpretation and report of the Chest X-rays), if performed by an independent billing physician/radiologist (not affiliated with the hospital).

FAQ

N/A

Resources

- CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80, Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, sets forth the levels of physician supervision required for furnishing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient or outpatient.
- Article - Billing and Coding: Chest X-Ray Policy (A57497)

Related policies

- *Link to relevant related policies here*

Related denial language

N/A

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency which are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
10/08/2026	New policy created