ALH Radiation Oncology RCM Masterclass

Module 1

Intake and authorization

Module runtime: about 17 minutes

2026 Training Material | 2026 Edition

Course workflow

Work moves through the practice in this order

1. Intake and authorization
2. Coding and claim review
3. Denials and appeals
4. A/R and patient balances
5. Bilingual communication and desk tools

Why this topic matters

One course, many services

Consultation, simulation, planning, delivery, and management each need their own record and review.

One gap repeats

A site, unit, or date mismatch missed at intake can affect every fraction that follows.

2026 changed the codes

Conventional delivery and image-guidance coding were revised for 2026, and legacy codes were deleted.

Module 1 learning objectives

By the end of this module, you will be able to:

01 Identify the coverage, site, and authorization facts that must match

02 Connect the right source record to each stage of care

03 Build a complete authorization request for the planned course

04 Manage revisions and boosts before they become denials

01

MODULE

Intake and authorization

Lesson 1.1 The treatment and billing roadmap

Lesson 1.2 Complete authorization requests

Lesson 1.3 Authorization revisions and boosts

The treatment and billing roadmap

ALH EDUCATIONAL RECOMMENDATION

Connect the right record to each stage of care

1. Consultation and treatment decision
2. Simulation and planning
3. Delivery and treatment management
4. Follow-up and account reconciliation

BILLING TIP

A scheduled fraction is not delivered treatment, and an authorization is not a correct charge.

A schedule note without a prescription

FICTIONAL CASE

CASE FACTS

01 Coverage and site participation are confirmed

02 The schedule note says “IMRT, about 28 treatments”

03 No signed prescription or approved summary is on file

04 Start is in two weeks; a coworker wants to code from the schedule note

YOUR TASK

Write the next action, the evidence you need, and the person responsible.

Pause and write your answer before the review continues.

Complete authorization requests

PAYER-SPECIFIC EXAMPLE (eviCore via ASTRO 1/21/2026)

01 Exact payer product and review vendor

02 Clinical records organized by requirement

03 Codes and payer-defined quantities

04 Written approval matched to the request

BILLING TIP

Authorization is not a guarantee of payment. Save the approval itself and compare every field.

Requested quantity and approved quantity

FICTIONAL CASE

CASE FACTS

01 The request asks for 25 fractions

02 The approval lists 20 units

03 The schedule contains 25 treatments

YOUR TASK

Write the next action, the evidence you need, and the person responsible.

Pause and write your answer before the review continues.

Authorization revisions and boosts

ALH EDUCATIONAL RECOMMENDATION

A revised order and a revised approval are separate records

1. Change notification from the clinical team
2. Comparison with the original approval
3. Revision request and receipt evidence
4. Updated dates, quantities, and site

DOCUMENTATION TIP

Preserve the original and revised approvals with their effective dates.

A boost outside the approval

FICTIONAL CASE

CASE FACTS

01 All 20 approved units have been used

02 The approval ends October 30

03 Five boost fractions begin November 2

YOUR TASK

Write the next action, the evidence you need, and the person responsible.

Pause and write your answer before the review continues.

Check your understanding

Which statement about financial clearance is accurate?

A. Active coverage confirms that the treatment site is in network

B. An authorization number confirms that the charge is correct

C. A scheduled fraction does not establish that treatment was delivered — CORRECT

D. Staff may code from the appointment label when the prescription is late

A different treatment location

FICTIONAL CASE

An authorization contains the requested codes but names a different treatment location. What should staff verify before closing the task?

A. Nothing more; matching codes are enough to close it

B. The approved site and billing arrangements versus the actual location — CORRECT

C. Only that the patient's coverage is active

D. Whether scheduling can move treatment to the approved site

A boost after all units are used

FICTIONAL CASE

A physician adds a boost after all approved units are used. What should staff do next?

A Bill the boost under the existing authorization number

B Request approval after the boost is complete

C Ask the physician to cancel the boost

D Obtain the revised prescription and confirm the payer's amendment or new-request rule — CORRECT

References

S2 **ASTRO.** Major Radiation Oncology Code Changes in 2026 (ASTROnews). Winter 2026. https://www.astro.org/news-and-publications/astronews/2026/winter-astronews/society-news/major-radiation-oncology-code-changes-in-2026

S3 **ASTRO.** IGRT: Coding FAQs and Tips. 2026 coding guidance; accessed Oct 6, 2026. https://www.astro.org/practice-support/reimbursement/coding/coding-guidance/coding-faqs-and-tips/igrt

References

S4 **ASTRO.** ASTRO continues prior authorization advocacy. January 21, 2026. https://www.astro.org/news-and-publications/what-is-happening-in-washington/2026/astro-continues-prior-authorization-advocacy

S7 **ASTRO.** ASTRO Updates: New Treatment Delivery and Image Guidance Codes. February 26, 2026. https://www.astro.org/news-and-publications/what-is-happening-in-washington/2026/astro-updates-new-treatment-delivery-image-guidance-codes

Module 1 complete

01 Map the full course before you clear the account

02 Match coverage, site, provider, and approval before clearance

03 Preserve the original and revised approvals

04 Next: Module 2, coding and claim review

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