ALH Radiation Oncology RCM Masterclass

Module 2

Coding and claim review

Module runtime: about 18 minutes

2026 Training Material | 2026 Edition

Module 2 learning objectives

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

01 Distinguish 77402, 77407, and 77412 by documented delivery characteristics

02 Decide when an E/M is separately reportable from treatment management

03 Apply modifiers 25, 26, and TC only when their requirements are met

04 Run the six-step daily prebill audit before claims are released

02

MODULE

Coding and claim review

Lesson 2.1 E/M and treatment management
Lesson 2.2 Modifiers 25, 26, and TC
Coding lab 2026 conventional delivery
Lesson 2.3 The daily prebill audit

E/M and treatment management

FEDERAL / MEDICARE (NCCI Policy Manual Ch. IX §F.1, rev. 1/1/2026)

01 Encounter purpose and documented work

02 Payer rules for separate reporting

03 Correct family and patient status

04 Management charges tied to actual treatment

DOCUMENTATION TIP

A new diagnosis alone does not establish a new patient.

An automatic weekly E/M charge

FICTIONAL CASE

CASE FACTS

01 A weekly treatment note triggers 99214

02 The note documents routine treatment review

03 The system adds modifier 25 automatically

YOUR TASK

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

Pause and write your answer before the review continues.

Modifiers 25, 26, and TC

CPT 2026 (AMA) / MEDICARE

Modifier 25

Significant, separately identifiable E/M on the same day

Goes on the E/M line when requirements are met

Does not make routine treatment management billable

Modifiers 26 and TC

26: professional component; TC: technical component

Only when the code permits component billing

A professional-only code does not automatically need 26

PAYER-SPECIFIC

77387 is the 2026 professional image-guidance code. Modifier handling varies by payer (ASTRO 2/26/2026). Check code status, setting, and the payer rule.

A modifier rejection on 77387

FICTIONAL CASE

PAYER-SPECIFIC (varies; ASTRO 2/26/2026)

CASE FACTS

01 A payer rejects a modifier on 77387

02 A coworker proposes a change for all payers

03 The current product-specific rule is missing

YOUR TASK

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

Pause and write your answer before the review continues.

2026 conventional delivery levels

CPT 2026 (AMA) / MEDICARE

01 77402, 77407, and 77412 are the three 2026 delivery levels

02 Level depends on documented delivery characteristics

03 77407: for example, single-isocenter photon delivery

04 77412: specified higher complexity, such as multiple isocenters or active motion management

05 IMRT or VMAT alone does not establish level 3

Review the record behind each charge

ALH EDUCATIONAL RECOMMENDATION

Simulation and planning

Find the completed service. Check whether the charge is included in another service.

Dosimetry and devices

Locate the calculation or construction record. The coder validates units and frequency.

Delivery and image guidance

Match the treatment record to the date and technique. Assess professional guidance separately.

Specialized modalities

Route SRS, SBRT, brachytherapy, proton, radiopharmaceutical, and superficial questions to their own rules.

IMRT proposed as level 3

FICTIONAL CASE

CPT 2026 (AMA) / MEDICARE

CASE FACTS

01 2026 record: photon IMRT, one isocenter

02 No active motion management; no specialized category

03 The interface proposes 77412 solely because it is IMRT

YOUR TASK

What should the review flag, and which code is reviewed next?

Pause and write your answer before the review continues.

DIBH as the only detail

FICTIONAL CASE

CPT 2026 (AMA) / MEDICARE

CASE FACTS

01 The note states only “DIBH”

02 The authorization request proposes 77412

03 The stated basis is active motion management

YOUR TASK

What clinical detail is needed before the code review can finish?

Pause and write your answer before the review continues.

The daily prebill audit

ALH EDUCATIONAL RECOMMENDATION

A brief, repeatable reconciliation before release

1. Reconcile services to charges
2. Validate demographics, coverage, and identifiers
3. Match the authorization
4. Confirm records, codes, units, and modifiers
5. Check history and deadlines
6. Release and confirm acceptance

DENIAL PREVENTION TIP

Never move a service to another date to avoid an edit. The record sets the date.

Three exceptions in one batch

FICTIONAL CASE

CASE FACTS

01 One canceled treatment still has a charge

02 One performed service has no charge

03 One service falls outside the approval dates

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

CPT 2026 (AMA) / PAYER-SPECIFIC (ASTRO 2/26/2026)

For 2026 conventional delivery, which statement about image guidance is accurate?

A. Technical image guidance is billed separately with 77014

B. 77387 is the professional service; technical guidance is in delivery — CORRECT

C. Deleted G-codes may still be used for early 2026 dates

D. 77387 needs modifier 26 for every payer

IMRT mapped to the highest level

FICTIONAL CASE

The charge interface assigns the highest delivery level to all IMRT treatments. Why is this insufficient for the 2026 family?

A Technique alone does not establish delivery complexity — CORRECT

B IMRT can never be reported with 77412

C The 2026 family has only one delivery code

D The level depends on the number of treatment fields

An automatic E/M with modifier 25

FICTIONAL CASE

A routine weekly treatment note automatically generates an office E/M with modifier 25. What should the reviewer do?

A. Keep the charge, because modifier 25 clears the edit

B. Change the E/M to a lower level and release it

C. Hold it for radiation-specific coding review and fix the automation — CORRECT

D. Release it and appeal any denial

One payer rejects a 77387 modifier

FICTIONAL CASE

One payer rejects a modifier on 77387. Should staff remove that modifier from every payer's claims?

A. Yes, remove it from every payer's claims today

B. No; verify that payer's current written rule and limit the fix — CORRECT

C. No; resubmit the same claim until it pays

D. Yes, and remove modifier 26 from all codes

References

S1 **CMS.** NCCI Policy Manual for Medicare Services, Chapter IX: Radiology Services (CPT 70000-79999). Revision date 1/1/2026. https://www.cms.gov/files/document/09-chapter9-ncci-medicare-policy-manual-2026-final.pdf

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

S5 **CMS (MLN).** Evaluation and Management Services, MLN006764. May 2026. https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf

References

S6 **CMS.** Status Indicators. Page last modified July 14, 2026. https://www.cms.gov/help/status-indicators

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 2 complete

01 Let documented facts, not templates, drive codes and modifiers

02 IMRT or VMAT alone does not establish level 3

03 Never move a service to another date to avoid an edit

04 Next: Module 3, denials and appeals

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