ALH Radiation Oncology RCM Masterclass

Module 3

Denials and appeals

Module runtime: about 14 minutes

2026 Training Material | 2026 Edition

Module 3 learning objectives

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

01 Choose correction, reprocessing, appeal, or posting from remittance codes

02 Read the group code, reason, remarks, and amounts together

03 Build an appeal packet tied to the specific disputed determination

04 Track formal appeal deadlines separately from informal promises

03

MODULE

Denials and appeals

Lesson 3.1 ERA and EOB review

Lesson 3.2 A supported appeal packet

Lesson 3.3 Escalation and formal deadlines

ERA and EOB review

X12 STANDARD

Read the group code, reason, remarks, and amounts together

1. Match the line to the original claim
2. Rejected, or adjudicated and denied?
3. Read every reason and remark
4. Choose: correct, supply, reprocess, appeal, or post
5. Record deadline, evidence, and owner

DENIAL PREVENTION TIP

Never move a CO denial to the patient just to close the insurance balance.

A bundling denial

FICTIONAL CASE

CASE FACTS

01 The remittance shows CO-97

02 The related paid service is unknown

03 A coworker suggests modifier 59

YOUR TASK

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

Pause and write your answer before the review continues.

A supported appeal packet

MEDICARE FFS ONLY (120 days)

01 Specific disputed determination

02 Evidence tied to the applicable criterion

03 Indexed supporting documents

04 Correct route and proof of receipt

WARNING

Medicare FFS redetermination: 120 days from receipt of the initial determination (receipt is presumed 5 calendar days after the notice date). Not universal for other plans or levels.

Correction or appeal

FICTIONAL CASE

CASE FACTS

01 The payer denies the claim for missing authorization

02 A matching approval exists

03 The claim contains a mistyped authorization number

YOUR TASK

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

Pause and write your answer before the review continues.

Escalation and formal deadlines

FEDERAL (ERISA/EBSA) / STATE

01 Chronology with receipt evidence

02 Precise request for the next action

03 Formal deadline tracked separately

04 Escalation route matched to the plan

WARNING

A phone call, complaint, or representative email does not extend a formal appeal deadline.

A promise before the deadline

FICTIONAL CASE

CASE FACTS

01 A representative promises help

02 The appeal deadline is five days away

03 The account has no formal appeal receipt

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

A remittance applies the full allowed amount to the patient's deductible, so the line pays zero. What comes first?

A. Appeal the claim for nonpayment

B. Add modifier 59 and resubmit

C. Write off the balance to close the account

D. Confirm correct processing and a valid patient amount — CORRECT

A CO-97 on the remittance

FICTIONAL CASE

A remittance reports CO-97. What must be investigated before appealing or adding a modifier?

A. Whether the patient can pay the balance

B. Whether modifier 59 clears the edit on resubmission

C. The related service and the edit or policy that includes payment — CORRECT

D. Nothing; CO-97 always calls for an appeal

A promise and a deadline tomorrow

FICTIONAL CASE

A payer representative promises help, but the formal appeal deadline is tomorrow. What action protects the account?

- **A** File the formal dispute through the required route by the deadline — CORRECT
- **B** Wait for the representative's callback
- **C** Ask the representative to extend the deadline by email
- **D** Move the balance to the patient

References

S8 **X12.** Claim Adjustment Reason Codes. Maintained code list; accessed Oct 6, 2026. https://x12.org/codes/claim-adjustment-reason-codes

S9 **CMS.** First Level of Appeal: Redetermination by a Medicare Contractor. Page last modified March 10, 2026. https://www.cms.gov/medicare/appeals-grievances/fee-for-service/first-level-appeal-redetermination-medicare-contractor

S10 **U.S. Department of Labor, EBSA.** Filing a Claim for Your Health Benefits. Undated; accessed Oct 6, 2026. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits

Module 3 complete

01 Read the full remittance, then choose the route

02 Never move a CO denial to the patient just to close the balance

03 Protect formal deadlines; promises do not extend them

04 Next: Module 4, A/R and patient balances

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