Medical Billing, Coding, and Claims Denial Management Training Course

21 - 25 Dec 2026

Rome

5800 € (Per Person)

Ref: #HOS6035_110730

Course Introduction / Overview:

This comprehensive training course provides a deep and practical understanding of the entire healthcare revenue cycle, from patient registration to final payment resolution. In an era of increasing regulatory complexity and financial pressures on healthcare providers, mastering medical billing, coding, and claims denial management is no longer optional but essential for organizational viability. This program is meticulously designed to equip participants with the critical skills needed to ensure accurate coding, clean claim submissions, and effective management of denied claims, thereby optimizing revenue streams and improving financial performance. Drawing upon established principles in health information management, such as those detailed by experts like Carol J. Buck in works like "Step-by-Step Medical Coding," this course bridges theory with real-world application. Participants will learn to navigate the intricacies of ICD-10-CM, CPT, and HCPCS coding systems, understand the nuances of payer policies, and develop strategic approaches to prevent and appeal claim denials. BIG BEN Training Center has developed this curriculum to empower healthcare professionals to become pivotal assets in their organizations, safeguarding financial health through precision and expertise in the complex world of healthcare reimbursement.

Target Audience / This training course is suitable for:

- Medical Billing Specialists.
- Medical Coders and Coding Auditors.
- Claims Adjudicators and Analysts.
- Healthcare Administrators and Office Managers.
- Revenue Cycle Management Staff.
- Health Information Management Professionals.
- Patient Account Representatives.
- Compliance Officers in Healthcare.
- Physicians and other Clinical Providers seeking to understand the billing cycle.
- Finance and Accounting Professionals in the healthcare sector.

Target Sectors and Industries:

- Hospitals and Health Systems.
- Physician Practices and Private Clinics.
- Dental and Specialty Medical Offices.
- Third-Party Medical Billing Companies.
- Health Insurance and Payer Organizations.
- Governmental Healthcare Agencies and Public Health Departments.
- Long-Term Care Facilities and Nursing Homes.
- Outpatient Surgical and Diagnostic Centers.
- Healthcare Consulting Firms.
- Durable Medical Equipment (DME) Suppliers.

Target Organizations Departments:

- Revenue Cycle Management.
- Finance and Accounting.
- Patient Financial Services.
- Health Information Management (HIM).
- Billing and Collections.
- Compliance and Auditing.
- Admitting and Patient Registration.
- Clinical Administration.
- Operations Management.
- Provider Relations.

Course Offerings:

By the end of this course, the participants will have able to:

- Master the application of ICD-10-CM, CPT, and HCPCS Level II coding systems for accurate claim submission.
- Analyze the complete healthcare revenue cycle from patient intake to account closure.
- Identify common causes of claim denials and implement proactive prevention strategies.
- Develop and write effective, evidence-based appeal letters for denied claims.
- Navigate complex payer policies and reimbursement guidelines to ensure compliance.
- Conduct internal audits of coding and billing practices to identify areas of risk and opportunity.
- Utilize electronic health records (EHR) and practice management systems for efficient billing operations.
- Ensure adherence to healthcare regulations, including HIPAA and OIG compliance guidelines.
- Improve communication between clinical and administrative staff to reduce billing errors.
- Enhance the financial performance of their organization by reducing accounts receivable days and increasing clean claim rates.

Course Methodology:

The training methodology at BIG BEN Training Center is designed to be highly interactive, practical, and engaging, ensuring that participants can immediately apply their learning in a professional setting. This course moves beyond traditional lectures by incorporating a blended learning approach. A significant portion of the training is dedicated to hands-on exercises, including the coding of real-world, anonymized medical case studies and the dissection of complex claim denial scenarios. Participants will work in collaborative groups to perform root cause analysis on denied claims and strategize effective appeal processes. Interactive workshops and guided discussions will facilitate the sharing of experiences and best practices among attendees. The curriculum includes detailed walkthroughs of the claim's submission and adjudication process, simulating the challenges faced in daily operations. Our expert instructors provide continuous, constructive feedback throughout the sessions, fostering a supportive learning environment where questions are encouraged. This immersive, problem-solving approach ensures a deep and lasting understanding of medical billing, coding, and denial management principles.

Course Agenda (Course Units):

Unit One: Foundations of the Healthcare Revenue Cycle

- Introduction to the U.S. healthcare payment systems.
- The key stages of the revenue cycle management (RCM) process.
- Understanding medical terminology, anatomy, and physiology for coders.
- The roles and responsibilities of billers, coders, and claims specialists.
- Introduction to major coding manuals: ICD-10-CM, CPT, and HCPCS Level II.
- The importance of accurate patient registration and data capture.
- Legal and ethical considerations in medical billing and coding.

Unit Two: Mastering Medical Coding Systems

- In-depth guide to ICD-10-CM coding for diagnoses.
- Applying CPT and HCPCS Level II codes for procedures and services.
- Understanding and using modifiers to enhance coding specificity.
- Linkage between diagnosis and procedure codes (medical necessity).
- Practical coding exercises for various medical specialties.
- Navigating the National Correct Coding Initiative (NCCI) edits.
- Staying current with annual updates to coding systems.

Unit three: The Medical Billing and Claims Submission Process

- The lifecycle of a medical claim from creation to submission.
- Charge capture, charge entry, and claims scrubbing techniques.
- Understanding the CMS-1500 and UB-04 claim forms.
- Electronic claims submission and clearinghouse processes.
- Payer-specific billing guidelines and requirements.
- Introduction to payment posting, adjustments, and reconciliation.
- Managing patient statements and collections.

Unit Four: Proactive Claims Denial Management

- Identifying and categorizing common denial reason codes.
- Performing root cause analysis for recurring claim denials.
- Strategies for preventing denials at the front-end and back-end.
- The formal appeals process for different payers.
- Crafting compelling and evidence-based appeal letters.
- Tracking and trending denial data for process improvement.
- Negotiating with payers and managing underpayments.

Unit Five: Compliance, Auditing, and Advanced Topics

- Ensuring compliance with HIPAA, Stark Law, and Anti-Kickback statutes.
- The role of the Office of Inspector General (OIG) in healthcare.
- Conducting internal and external coding and billing audits.
- Introduction to value-based care and its impact on billing.
- Credentialing and its importance in the billing process.
- Utilizing technology and automation in revenue cycle management.
- Future trends and career pathways in medical billing and coding.

FAQ:

Qualifications required for registering to this course?

There are no requirements.

How long is each daily session, and what is the total number of training hours for the course?

This training course spans five days, with daily sessions ranging between 4 to 5 hours, including breaks and interactive activities, bringing the total duration to 20 - 25 training hours.

Something to think about:

As artificial intelligence and machine learning become more integrated into healthcare, how might these technologies transform the process of medical coding and denial prediction, and what new skills will professionals need to remain relevant?

What unique qualities does this course offer compared to other courses?

This training course distinguishes itself by offering a holistic and integrated perspective on the revenue cycle, treating coding, billing, and denial management not as separate functions but as interconnected components of a single financial ecosystem. While many courses focus narrowly on coding rules or billing software, our curriculum emphasizes the critical thinking and analytical skills required to diagnose and solve complex revenue challenges. We move beyond theory by dedicating significant time to practical application, using real-world case studies and denial scenarios that mirror the complexities participants face daily. The program's strong focus on root cause analysis for claim denials equips attendees with a proactive, problem-solving mindset, enabling them to prevent future revenue loss rather than just reacting to it. Furthermore, the course content is forward-looking, addressing emerging trends like value-based care and the impact of technology, ensuring that the skills learned are not only relevant today but will also be invaluable in the evolving healthcare landscape. The interactive methodology fosters a collaborative environment where professionals can learn from both expert instructors and the shared experiences of their peers.