Revenue Cycle and Health Insurance Claim Optimization Training Course



26 - 30 Oct 2026

Geneva

5900 € (Per Person)

Ref: #HOS9741_111088

Course Introduction / Overview:

This comprehensive training course provides an in-depth exploration of the entire healthcare Revenue Cycle Management (RCM) process, from patient registration to final payment reconciliation. In today's complex healthcare landscape, efficient RCM and optimized claims processing are critical for the financial viability of any healthcare organization. This program is meticulously designed to equip participants with the essential skills to streamline workflows, reduce claim denials, accelerate cash flow, and ensure regulatory compliance. Drawing upon foundational principles outlined by experts like Dr. David I. Wukitsch in his seminal work, "Healthcare Finance: An Introduction to Accounting and Financial Management," the course delves into both the strategic and operational aspects of the revenue cycle. Participants will gain a robust understanding of front-end, mid-cycle, and back-end processes. BIG BEN Training Center has developed this curriculum to transform theoretical knowledge into practical, actionable strategies, empowering professionals to navigate the challenges of healthcare reimbursement and contribute directly to their organization's financial health and operational excellence. This is the definitive course for mastering the intricacies of managing healthcare revenue and optimizing insurance claims.

Target Audience / This training course is suitable for:

- Revenue Cycle Managers and Directors.
- Medical Billing and Coding Specialists.
- Healthcare Administrators and Practice Managers.
- Claims Processors and Adjudicators.
- Patient Financial Services Representatives.
- Healthcare Finance Professionals.
- Health Information Management (HIM) Staff.
- Compliance Officers in Healthcare.
- Insurance Payer Relations Specialists.
- Healthcare Consultants focused on finance.

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 Companies.
- Long-Term Care and Skilled Nursing Facilities.
- Ambulatory Surgery Centers.
- Diagnostic and Imaging Centers.
- Governmental Healthcare Agencies and Public Health Departments.
- Healthcare Technology and Software Vendors.

Target Organizations Departments:

- Finance and Accounting Departments.
- Billing and Collections Departments.
- Patient Access and Registration Departments.
- Health Information Management (HIM) Departments.
- Compliance and Legal Departments.
- Managed Care and Contracting Departments.
- Clinical Operations Departments.
- Information Technology (IT) Departments.

Course Offerings:

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

- Master the end-to-end healthcare revenue cycle from patient scheduling to final account resolution.
- Implement effective strategies for accurate patient registration and insurance eligibility verification.
- Apply correct medical coding principles (ICD-10, CPT, HCPCS) to ensure clean claim submissions.
- Develop proactive denial management and appeals processes to recover revenue.
- Analyze and improve key performance indicators (KPIs) such as Days in A/R and Clean Claim Rate.
- Navigate the complexities of payer contracts and healthcare reimbursement models.
- Ensure strict adherence to HIPAA, CMS guidelines, and other regulatory requirements.
- Utilize healthcare analytics to identify trends and opportunities for process improvement.
- Optimize charge capture and reconciliation processes to prevent revenue leakage.
- Enhance patient financial counseling and communication to improve collections.

Course Methodology:

The training methodology at BIG BEN Training Center is designed to be highly interactive, engaging, and practical, ensuring that participants can immediately apply their learning in a professional setting. This course moves beyond traditional lectures to create a dynamic learning environment. We utilize a blend of expert-led presentations, real-world case studies derived from complex billing scenarios, and interactive group discussions that encourage peer-to-peer learning and problem-solving. Participants will engage in hands-on exercises simulating key RCM tasks, such as analyzing denied claims, auditing medical codes, and developing effective appeal letters. Role-playing activities will be used to enhance skills in patient financial counseling and communication. Our approach emphasizes a continuous feedback loop, where instructors provide personalized guidance and facilitate sessions that connect theoretical concepts, like those found in healthcare finance literature, to the practical challenges faced in today's healthcare industry. The focus is on building tangible skills in claims optimization and revenue cycle efficiency, empowering attendees to drive measurable financial improvements within their organizations.

Course Agenda (Course Units):

Unit One: Fundamentals of Healthcare Revenue Cycle Management

- Introduction to the Revenue Cycle Management (RCM) framework.
- The key stages and stakeholders in the healthcare revenue cycle.
- Understanding the financial impact of an efficient RCM process.
- The role of technology and EHR/EMR systems in RCM.
- Introduction to key performance indicators (KPIs) for RCM.
- Regulatory landscape: HIPAA, HITECH, and the False Claims Act.
- The patient journey through the revenue cycle.

Unit Two: Front-End Processes: Patient Access and Financial Clearance

- Best practices for patient scheduling, pre-registration, and registration.
- Techniques for accurate insurance eligibility and benefits verification.
- The importance of prior authorization and pre-certification.
- Calculating patient financial responsibility and estimates.
- Effective patient financial counseling and communication strategies.
- Managing patient demographics and data integrity.
- Front-end strategies for preventing claim denials.

Unit Three: Mid-Cycle Processes: Coding, Charge Capture, and Claims Submission

- Fundamentals of medical coding: ICD-10-CM, CPT, and HCPCS.
- The principles of accurate charge capture and reconciliation.
- Understanding the UB-04 and CMS-1500 claim forms.
- The role of a Charge Description Master (CDM) in revenue integrity.
- Conducting internal coding and billing audits.
- The electronic claims submission process and clearinghouse functions.
- Strategies for achieving a high clean claim submission rate.

Unit Four: Back-End Processes: Claims Adjudication and Denial Management

- The claims adjudication process from the payer's perspective.
- Payment posting, remittance advice, and electronic funds transfer (EFT).
- Identifying, tracking, and categorizing claim denials.
- Developing a systematic approach to denial analysis and root cause identification.
- Crafting effective and compliant appeal letters.
- Managing Accounts Receivable (A/R) and follow-up strategies.
- Patient collections, payment plans, and bad debt management.

Unit Five: Advanced RCM Analytics, Compliance, and Optimization

- Analyzing RCM performance using key metrics and dashboards.
- Leveraging data analytics for process improvement and trend spotting.
- The transition from fee-for-service to value-based reimbursement models.
- Managing payer contracts and negotiations.
- Advanced strategies for revenue integrity and preventing revenue leakage.
- The future of RCM: AI, automation, and predictive analytics.
- Developing and implementing a corporate compliance plan for RCM.

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:

How can the integration of artificial intelligence and machine learning transform traditional denial management processes within the healthcare revenue cycle?

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

This course distinguishes itself by providing a holistic, 360-degree view of the revenue cycle, seamlessly integrating front-end, mid-cycle, and back-end processes into a unified strategic framework. Unlike programs that focus narrowly on billing or coding in isolation, our curriculum emphasizes the interconnectedness of each stage and how actions in one area, such as patient registration, directly impact outcomes in another, like denial rates. We move beyond theoretical knowledge by immersing participants in practical, real-world case studies and denial analysis workshops, fostering critical thinking and problem-solving skills essential for today's complex reimbursement environment. A significant differentiator is our forward-looking perspective, with dedicated modules on leveraging data analytics, preparing for value-based care models, and understanding the impact of emerging technologies like AI. The course is built on a foundation of proactive denial prevention rather than purely reactive management, equipping professionals with the foresight to build resilient and efficient revenue cycle systems that ensure financial stability and support quality patient care.