



Advanced Hospital Revenue Cycle and Financial Performance Training Course

5 – 9 April 2027
Kuala Lumpur

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Overview

Advanced Hospital Revenue Cycle and Financial Performance Training Course is a one-week course for hospital finance managers, revenue cycle leaders, billing supervisors, healthcare administrators, performance analysts, and service managers, who leave with a Hospital Revenue Cycle Performance Toolkit. The course addresses revenue leakage and delayed cash through patient access, charge capture, claims, denials, receivables, revenue integrity, performance analysis, and executive reporting. Agile Leaders Training Center frames hospital revenue cycle improvement as a coordinated operational discipline.

Who Should Attend

- Functions responsible for patient access, eligibility, authorization, and financial clearance
- Teams responsible for charge capture, billing, claim submission, and payment posting
- Functions responsible for denial prevention, appeals, accounts receivable, and collections
- Managers responsible for revenue integrity, payer communication, and service performance
- Analysts responsible for revenue cycle indicators, root causes, and executive reporting

The course assumes participants manage or analyze hospital revenue cycle processes and leaves out general budgeting, financial statement preparation, and clinical coding certification.

Departments and Industries

The course supports departments and organizations that manage patient-to-payment performance and healthcare service revenue.

- Hospitals, health systems, and ambulatory care networks
- Patient access, admissions, and financial clearance departments
- Billing, claims, revenue integrity, and accounts receivable functions
- Finance, performance improvement, and executive reporting teams
- Healthcare insurers, claims administrators, and revenue cycle service firms

Learning Objectives

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



- Analyze patient access and charge capture control points
- Build clean-claim and payer communication workflows
- Diagnose denial causes and prioritize prevention actions
- Apply accounts receivable and collections governance
- Use revenue cycle performance indicators and root-cause tools
- Evaluate revenue integrity results for executive decisions

Course Agenda

Day 1: Patient Access and Revenue Foundations

- Patient-to-Payment Revenue Cycle Process Map
- Eligibility and Benefit Verification Control Checklist
- Authorization and Financial Clearance Decision Matrix
- Patient Access Data Quality Audit Tool
- Front-End Revenue Leakage Risk Register

Day 2: Charge Capture and Clean Claims

- Charge Capture Reconciliation Framework
- Clinical Documentation and Coding Interface Map
- Claim Edit and Correction Workflow
- Clean-Claim Readiness Checklist
- Payer Submission and Acknowledgment Tracker

Day 3: Denials and Payer Resolution

- Denial Classification and Triage Matrix
- Claim Adjustment Reason Analysis Method
- Denial Root-Cause Analysis Tree
- Appeal Prioritization and Evidence Checklist
- Payer Communication and Escalation Protocol

Day 4: Receivables and Performance Governance

- Accounts Receivable Aging Segmentation Model
- Collections Worklist Prioritization Rules
- Underpayment and Variance Review Log
- Revenue Integrity Control Dashboard
- Executive Revenue Cycle Reporting Pack



Day 5: Hospital Revenue Cycle Practice

- Suggested Exercise: Front-End Control Gap Assessment
- Suggested Exercise: Clean-Claim Workflow Redesign
- Suggested Exercise: Denial Root-Cause Review
- Suggested Exercise: Performance Dashboard Briefing
- Capstone Exercise: Hospital Revenue Cycle Performance Toolkit

Practical Exercises

The course uses suggested activities based on fictional hospital, ambulatory, insurer, and service-provider situations.

- Suggested activity: map patient access, charge capture, claim, payment, and collections handoffs and identify control gaps.
- Suggested activity: classify denials, analyze recurring causes, and assign prevention, appeal, and escalation actions.
- Suggested activity: segment receivables, prioritize worklists, and record underpayment and collection decisions.
- Suggested activity: build a revenue integrity dashboard and present an executive improvement roadmap.

FAQs

Who suits hospital revenue cycle management training, and what does it assume?

Hospital finance, billing, operations, performance, and revenue cycle personnel suit the training; it assumes responsibility for managing or analyzing patient-to-payment processes and excludes general accounting, budgeting, and coding qualification.

How does hospital revenue cycle management differ from healthcare financial reporting training?

Hospital revenue cycle management improves operational flow from patient access through claims and collections, while healthcare financial reporting training concentrates on statements, accounting treatment, and formal financial presentation.

Which hospital revenue cycle indicators support financial performance decisions?

Useful hospital revenue cycle indicators connect clean claims, denials, receivable aging, collections, underpayments, write-offs, and cash performance to accountable process owners and defined review actions.



How does denial root-cause analysis improve hospital revenue cycle performance?

Denial root-cause analysis links recurring payment failures to patient access, authorization, documentation, charge, coding-interface, claim, or payer-process causes so teams can prioritize preventive controls.

What does revenue integrity add to hospital revenue cycle management?

Revenue integrity aligns charges, documentation interfaces, claim accuracy, payment variance review, compliance controls, and accountability so earned service revenue is recorded and pursued consistently.

Conclusion

Participants leave with a Hospital Revenue Cycle Performance Toolkit containing process maps, control checklists, denial analysis tools, receivable rules, dashboards, and reporting templates. The toolkit makes leakage points, responsibilities, and improvement priorities visible. It supports coordinated decisions across access, billing, finance, operations, and payer-facing teams.