CONCEPT

Medical Insurance Operations: Benefit Design, Pre-Authorisation and Claims Control

10 – 14 May 2027
Barcelona - Eixample district four-star



Medical Insurance Operations: Benefit Design, Pre-Authorisation and Claims Control

Ref: 376_13333 **Date:** 10 – 14 May 2027 **Location:** Barcelona - Eixample district four-star **Fees:** 23500 SAR

Introduction:

Medical insurance portfolios lose money quietly when tables of benefits are loosely worded, provider tariffs drift from contract, pre-authorisation requests are approved without medical-necessity checks and claims pass adjudication with duplicate, unbundled or upcoded lines. This Core Concept course gives insurer, third-party administrator and hospital insurance-office staff a working method for each stage of the member and claim journey, from benefit design and network contracting through eligibility, pre-authorisation, adjudication, rejections and appeals to loss ratio monitoring. Participants finish by assembling a Medical Claims Control Pack for their own operation.

Course Objectives:

- Interpret and draft tables of benefits, deductibles, co-payments, sub-limits and exclusions so that front-line staff and providers apply cover consistently
- Apply group pricing and underwriting inputs, including census data, claims experience and risk loadings, when quoting and renewing medical insurance schemes
- Negotiate and maintain provider network agreements, tariff schedules and package prices, and check invoiced charges against contracted rates
- Process member eligibility checks and pre-authorisation requests using medical-necessity criteria, turnaround targets and documented approval limits
- Adjudicate medical claims with coding checks, clean-claim edits and fraud, waste and abuse screening, then manage rejections, resubmissions, appeals and provider reconciliation
- Monitor medical loss ratio, cost drivers and service KPIs and propose cost-containment actions for a medical insurance portfolio

Target Audience:

- Staff who assess and process medical claims and apply policy terms to provider invoices
- Staff who handle pre-authorisation requests, case management and medical-necessity reviews for members
- Staff who recruit, contract and manage hospitals, clinics and pharmacies within a provider network
- Staff at hospitals and clinics who prepare insurance submissions, answer rejections and reconcile payer remittances
- Staff who design medical insurance products, quote group schemes and administer member enrolment
- Staff who investigate suspicious claims and run medical cost and service reporting

Course Outline:

Day 1: Medical Insurance Products, Stakeholders and Benefit Design

- Medical Insurance Value Chain: Insurer, Third-Party Administrator, Provider and Member Roles
- Product Types: Individual, Group, Self-Funded and Tiered Network Plans
- Table of Benefits Anatomy: Annual Limits, Sub-Limits, Deductibles and Co-Payments
- Exclusion Clauses, Waiting Periods and Pre-Existing Condition Wording
- Current-State Assessment of Policy Wording Ambiguities That Trigger Claim Disputes

Day 2: Pricing, Underwriting and Provider Network Contracting

- Group Pricing Inputs: Member Census, Age Bands and Claims Experience Rating
- Underwriting Rules: Medical Declarations, Risk Loadings and Renewal Adjustments
- Provider Network Tiering and Selection Criteria for Hospitals, Clinics and Pharmacies
- Tariff Schedules, Discount Agreements and Fixed Package Pricing for Procedures
- Provider Agreement Clauses: Submission Deadlines, Payment Terms and Audit Rights

Day 3: Eligibility, Pre-Authorisation and Claims Adjudication Workflow

- Member Enrolment Records, Card Issuance and Real-Time Eligibility Verification
- Pre-Authorisation Workflow: Request Intake, Medical-Necessity Criteria and Approval Limits
- Utilisation Review, Step Therapy and Inpatient Case Management Checkpoints
- Claims Adjudication Sequence: Registration, Benefit Matching, Pricing and Payment Decision
- Clean-Claim Edits: Diagnosis-to-Procedure Consistency, Duplicate Lines and Missing Documents

Day 4: Fraud, Waste and Abuse, Rejections and Medical Cost Control

- Fraud, Waste and Abuse Typologies: Phantom Billing, Upcoding, Unbundling and Kickbacks
- Red-Flag Rules, Provider Profiling and Outlier Analysis for Suspicious Claims
- Rejection Codes, Resubmission Rules and the Provider Appeal Review Process
- Provider Statement Reconciliation, Recoveries and Remittance Advice Matching
- Medical Loss Ratio Analysis, Cost Driver Breakdown and Service KPI Dashboard

Day 5: Claims Case Clinic and Medical Claims Control Pack

- Case Study: Reviewing a Disputed Inpatient Claim File from Pre-Authorisation to Payment
- Case Study: Screening a Pharmacy and Outpatient Batch for Duplicate and Unbundled Lines
- Case Study: Diagnosing a Rising Loss Ratio in a Corporate Group Scheme
- Control Checklist and Turnaround Standards Drafting for Each Operations Desk
- Medical Claims Control Pack Presentation and Peer Challenge

Skills You Will Gain:

- Benefit Schedule Interpretation
- Experience Rating
- Tariff Negotiation
- Medical-Necessity Review
- Claims Adjudication
- Suspicious Claim Detection
- Provider Reconciliation
- Loss Ratio Analysis

Why Attend This Course:

- Return with a Medical Claims Control Pack covering benefit checks, pre-authorisation rules, adjudication edits and a KPI dashboard for your own desk
- Reduce leakage from duplicate, unbundled and over-tariff claims before payment rather than chasing recoveries afterwards
- Settle rejection and appeal disputes with providers faster by applying clear contract, coding and documentation evidence
- Compare practice with colleagues from insurers, third-party administrators and hospital insurance offices across several health systems

Conclusion:

A medical insurance scheme stays sustainable only when product wording, pricing, network contracts and claim decisions work from the same rules. The course moves from products and benefit design, through group pricing, underwriting and provider tariffs, to eligibility, pre-authorisation and claims adjudication, and then to fraud, waste and abuse screening, rejections, appeals, reconciliation and loss ratio control. The final day applies these methods to real-style claim files and assembles a Medical Claims Control Pack ready for use by an operations team.