CAPLINE
HEALTHCARE MANAGEMENT

WHITEPAPER

Enhancing Revenue Through Improved Clinical Documentation

-Here's How to Ace it

www.caplinehealthcaremanagement.com

INTRODUCTION

An efficient revenue cycle relies on detailed, accurate and prompt data. Yes, an adequately documented clinical record is vital for successful revenue cycle management as it allows a higher level of coding which eventually increases per patient reimbursements.

With the surge in the complexity of medical billing, documenting charts adequately becomes utmost important. Healthcare providers invest about two to three hours every day collating data into patient records, which includes clinical documentation as well. Such administrative work hinders healthcare providers from paying complete attention to patient care. With efficient and real-time clinical documentation support, every provider can increase daily productivity by 20-30%, thereby making their practice more profitable.

As far as value-based patient care is concerned, data accuracy, improved clinical documentation, and coding is becoming more crucial to amplifying revenue and enhancing the quality of patient care. Statistically, nearly 90% of hospitals that used clinical documentation improvement solutions earned at least $1.5 million more in healthcare revenue and claims reimbursement, according to a 2016 Black Book Market Research survey.

Why do we need Improved Clinical Documentation?

Multiple researches and studies post implementation of HITECH Act have proven that workflow and strategies implemented to improve clinical documentation have boosted clinical efficiency, patient satisfaction, and maximized claims reimbursement revenue. In addition to better coded charts, adequately documented reports aid in better medical decision making and help to paint an accurate picture of the severity of a patient's illness and the treatment they require.

In addition to its impact on patient care, the true essence of improved clinical documentation is to maximize revenue, enhance your patient base, and nullify clinical documentation related burn-out.

By collaborating with trained and experienced medical scribes focused on clinical documentation improvement (CDI), providers are likely to generate an additional $2,500 per patient by producing optimally coded clinical notes and near-zero claim rejections.

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How Does Clinical Documentation Impact Your Practice?

There's no denying that neglecting the significance of clinical documentation invites a lot of financial and legal adversities to healthcare providers. Today's modern healthcare practice demands accurate patient documentation, as it is an essential part of medical care. If the quality of clinical documentation is poor or not efficient, it may result in revenue loss.

Safeguard Your Credibility

While filling out the paperwork may seem like a cake-walk, overlooking the consequences of incomplete or poor patient documentation is huge. A healthcare practitioner can lose his or her license by forgetting to note comorbidities or serious allergies while outlining a treatment plan for the patient.

Allegations of Fraud and Negligence

Incomplete medical documentation exhibits the poor quality of patient care and services, and this may be used to support allegations of negligence by patients or insurance companies, by patients or insurance companies. As a result, it can lead to legal implications and added stressors.
Therefore, identifying the importance of improved clinical documentation is necessary, and collaborating with clinical documentation specialists/Medical Scribes will help in:

- Meeting industry standards of documentation
- Constantly reviewing previous records
- Increase in revenue
- Effective coding
- Consistent cash flow
- Timely reimbursement

Realizing the Benefits of Improved Clinical Documentation

Implementing an improved clinical documentation within your healthcare system helps you in reaping several benefits which include:

01 Maximize the Overall Productivity of Your Organization

It helps lessen the strain on the doctors and supporting staff and helps them focus on providing quality healthcare to their patients.

02 Improved Patient Care and Satisfaction

Accurate and detailed clinical documentation aids in better medical decision making. With experts taking care of clinical documentation, it liberates you from note taking during visits and allows you to practice more empathetic interactions with your patients eventually enhancing patient satisfaction and improved ratings for you. With real-time clinical document reference support available during the visit, providers are better informed about the conditions of patients, which helps in identifying the right treatment and care for their patients.

03 Reduces Errors and Protects Quality

Incorrect patient demographics and coding mistakes slow down the reimbursement process, and it also hampers the quality of patient care. Improved clinical documentation reduces errors such as missing patient information, incorrect patient demographics, and coding mistakes.

04 Improves denial management

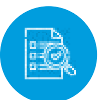
With improved clinical documentation, you can be assured that every claim is accepted and reimbursed fully and on time. When a trained team of clinical documentation specialists takes care of documentation, there is a near zero error rate. They also prevent denials and improve efficiency, ensuring continued stability in the revenue cycle.

How Capline's Improved Clinical Documentation Services Help in Enhancing Your Revenue?

Capline Healthcare Management offers industry-leading clinical documentation and medical scribe services that ensure your business is always on the cutting edge of healthcare.

Minimizes Burnout

Eliminate the documentation stress and give all the care to your patients with our advanced clinical documentation and medical scribe services.



Streamlined Documentation

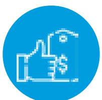
We provide trained scribes for accurate real-time & efficient charting to help improve the efficiency of the doctor-patient interaction and ensure the accuracy of all the important health records.

HIPAA Compliant Program

Capline Healthcare Management offers HIPAA-compliant service modeled through a Google-backed encrypted conference platform which helps to safely boost the organization's productivity.

Maximum Productivity

Healthcare providers have administrative duties apart from their clinical responsibilities. Some providers have to spend hours trying entering clinical data into EHRs, and this increases the risk of burnout and reduced productivity if you do not take assistance from trained medical scribes.



Customized Pricing

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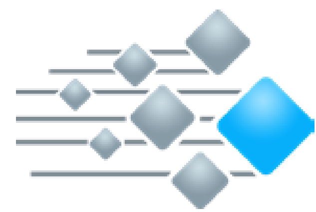
TAKEAWAY

Implementation of Improved clinical documentation is a very crucial decision for a flourishing healthcare organization as payers demand more accurate clinical and providers data to improve the reimbursement process as well as helps you drive an overall hike in the revenue and quality of patient care.

Pave your way to enhanced revenue and growth with Capline Healthcare Management's medical scribe services today!



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