



CAPLINE
HEALTHCARE MANAGEMENT



THE CRUCIAL ROLE OF
**CODING AND CLINICAL
DOCUMENTATION**
IN RESOLVING CLAIMS



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Overview

Efficient and accurate claim submission is essential to boost financial health and improve the operational success of medical practices. Undeniably, coding and clinical documents have an important role to play in the claims process and overall revenue cycle management of healthcare practices. This whitepaper explores the importance of coding and clinical documentation in resolving claims. Additionally, it highlights the challenges faced by medical practices and provides strategies for improvement. Enhancing coding accuracy and ensuring comprehensive clinical documentation can help healthcare organizations optimize claims submission along with enhancing patient care. Read the whitepaper to learn more.

Introduction

Efficient claims resolution is a complex task that involves numerous stakeholders, detailed processes, and adherence to the ever-evolving regulatory guidelines. In such a scenario, accurate coding and improved clinical documentation serve as important pillars in the claim resolution process to ensure timely reimbursement for healthcare providers.

According to a 2016 Black Book Market survey, approximately 90% of healthcare facilities that used clinical document improvement (CDI) for medical billing and coding saw a significant increase in their collections by at least 1.5 million. On the other hand, accurate coding is dependent on comprehensive clinical documentation and when both are associated with each other in the claims resolution process.

Claim denials can directly impact a practice's cash flow and negatively impact the financial health of healthcare facilities. Studies claim that a healthcare facility risks approximately \$4.9 million each year due to claim denials, and claim appeals cost hospitals up to \$8.6 billion annually. Thus, resolving claims efficiently is essential for the financial stability and success of medical practices. Coding and clinical documentation if done accurately can yield several benefits for healthcare organizations. However, healthcare providers might face various challenges in medical coding and clinical documentation if they do not have the right experts and knowledge to ace it, hindering the claims resolution process.



The Impact of Improved Clinical Documentation and Coding in Resolving Claims

Quality clinical documentation and accurate coding are vital for preventing claim denials and delivering the highest quality care to patients. Hence, health-care providers must understand how both these fundamental elements of medical billing can affect reimbursements and their financial success.

Health insurance companies can reject a claim for several reasons. Claims that have incorrect or missing information and a coding error can lead to insurers rejecting to cover patient healthcare services, delaying reimbursement for healthcare providers. Yes, payers use medical records to verify if a health-care provider is getting billed for the appropriate services.

Missing medical information or incorrect clinical documentation and coding errors amount to 15% of total claim denials, according to the changed Healthcare Denial Index of 2020. Thus, claim denials are a chief cause of medical revenue loss, and the primary sources of denials are clinical documentation-related and coding-related denials. But, improved clinical documentation and accurate medical coding can help healthcare providers prevent revenue leakage and resolve claim denials, resulting in a higher clean claim rate.

How to Implement Accurate Coding and Improved Clinical Documentation to Prevent Claim Denials

To enhance claims resolution, healthcare organizations must implement strategies to improve coding accuracy and clinical documentation. Optimizing coding and clinical documentation practices can yield several benefits for healthcare organizations. Coding and clinical documentation must adhere to various regulatory and compliance guidelines to ensure accurate claims resolution.

Here are the best ways and key strategies to improve your clinical documentation and medical coding:

#1

Comprehensive training and education for coding staff is crucial, and healthcare providers must ensure that. Doing so will help your coding staff stay up to date with coding guidelines and meet industry standards, resulting in the ability to resolve claims faster.

#2

Billing team should have proper training on the best clinical documentation practices. It will help them document the right procedures in the medical records and support accurate coding and claim submission.

#3

Leveraging electronic health records (EHR) can enhance the accuracy of clinical documentation and medical coding, leading to near-zero errors and denials.

#4

Outsourcing to professionals who are experts at handling clinical documentation and medical coding can help healthcare providers in the best way. It will not only ensure optimum claims resolution but also save a lot of time for providers and help them see more patients in a day.




Capline Healthcare Management Can Help!

As a healthcare provider, you may be struggling with several headwinds, from facing shortages of staff to delayed reimbursement or pending unresolved claims, all directly impacting your revenue cycle. Well, here is the good news!

Capline Healthcare Management is one of the fastest-growing medical billing companies in the United States, with years of expertise in handling medical billing and resolving claims. We have a team of highly-knowledgeable certified billers and industry experts who can help implement strategies to improve clinical documentation and medical coding. Thus, helping healthcare organizations enhance claims resolution, receive proper reimbursement, and make their practice profitable.


We bring in comprehensive solutions to improve clinical documentation and medical coding that are proven to yield better revenue for providers. Visit our website to avail of our services.

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