Severity-Based Quality Ratings and Reimbursement

Frequently Asked Questions (Physicians)

Beginning in April 2024, Penn Highlands Healthcare will be expanding quality documentation efforts by enhancing our existing Quality Documentation Program. Claro Healthcare, a nationally recognized healthcare consulting firm specializing in hospital and physician services, will be helping us with these efforts. Below are frequently asked questions about the initiative.

Why are physician and hospital quality ratings or peer comparisons important?

Quality ratings and peer comparisons are utilized externally by consumers, payors and employers to make decisions concerning healthcare. Appropriately reflecting the severity of our patients' illnesses provides for accurate cost, length-of-stay and mortality statistics. Consumers can now gain access to hospital and physician profiles and ratings via the internet.

How does documentation impact quality ratings/ peer comparisons?

Documentation in the medical record is the foundation for the coding and billing of the patient stay, which is the basis for the data utilized in quality ratings. Nursing and ancillary department documentation provides hints and clues in the record for additional documentation from the physician that may indicate a higher patient acuity. Coding rules will not allow diagnoses and/or procedures to be coded from lab, x-ray, nursing notes, PA notes, etc. unless there is physician documentation of the corresponding diagnosis in the medical record; therefore, without physician documentation of all diagnoses and procedures, a patient's severity may be understated.

How will we ensure accurate depiction of severity of illness and quality of care?

Penn Highlands will have a Clinical Documentation Specialist (CDS) assist the medical staff. The Clinical Documentation Improvement (CDI) team and the Health Information Management (HIM) coding staff will receive extensive, nationally accredited education for accurately capturing the severity of illness and quality of care provided to our patients. The CDS will review the medical record during the patient stay and will assist us in identifying opportunities to clarify documentation on a concurrent basis, allowing us to confirm the profile of patient conditions and, therefore, the resulting DRG that best reflects the severity of the patient.

What do physicians need to do?

The program is designed so that there will be very limited change in the time required for the medical staff to provide the accurate and necessary documentation, so that you can remain focused on high-quality care. The responsibility of the medical staff is to respond to queries from the CDI team, as the physician deems appropriate, by updating the documentation in the progress notes.

To learn more or if you have any questions, please contact one of the following:

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