General Comments on 1st Quarter 2019 Data

The following general comments about the data for this quarter are made by THCIC and apply to all data released for this quarter.

· Data are administrative data, collected for billing purposes, not clinical data.

· Data are submitted in a standard government format, the 837 format used for submitting billing data to payers. State specifications require the submission of additional data elements. These data elements include race and ethnicity. Because these data elements are not sent to payers and may not be part of the hospital's standard data collection process, there may be an increase in the error rate for these elements. Data users should not conclude that billing data sent to payers is inaccurate.

· Hospitals are required to submit the patient's race and ethnicity following categories used by the U. S. Bureau of the Census. This information may be collected subjectively and may not be accurate.

· Hospitals are required to submit data within 60 days after the close of a calendar quarter (hospital data submission vendor deadlines may be sooner). Depending on hospitals' collection and billing cycles, not all discharges may have been billed or reported. Therefore, data for each quarter may not be complete. This can affect the accuracy of source of payment data, particularly self-pay and charity categories, where patients may later qualify for Medicaid or other payment sources.

· Conclusions drawn from the data are subject to errors caused by the inability of the hospital to communicate complete data due to reporting form constraints, subjectivity in the assignment of codes, system mapping, and normal clerical error. The data are submitted by hospitals as their best effort to meet statutory requirements.

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PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
QUARTER: 1
YEAR: 2019

Certified With Comments

I certify this data is correct to the best of my knowledge as of this date of certification.

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PROVIDER: St Joseph Regional Health Center

THCIC ID: 002001
QUARTER: 1
YEAR: 2019

Certified With Comments

Errors existing in provider's data are insignificant in count. Every effort to properly code patient records correctly is exercised by provider staff.

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PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
QUARTER: 1
YEAR: 2019

Certified With Comments

The data included in this file is administrative, not clinical research data. Administrative data may not accurately represent the clinical details of a patient visit. This data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006001
QUARTER: 1
YEAR: 2019

Certified With Comments

The data included in this file is administrative, not clinical research data. Administrative data may not accurately represent the clinical details of a patient visit. This data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: CHRISTUS Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 1
YEAR: 2019

Certified With Comments

This data is submitted in an effort to meet statutory requirements. Conclusions drawn could be erroneous due to communication difficulties in reporting complete

data caused by reporting constraints, subjectivity in assignment of codes, various system mapping and normal clerical error. Data submission deadlines prevent inclusion of all applicable cases therefore this represents administrative claims data at the time of preset deadlines. Diagnostic and procedural data may be incomplete due to data field limitations. Data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Kindred Hospital-Dallas
THCIC ID: 028000
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 130 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: CHRISTUS Good Shepherd Medical Center-Longview
THCIC ID: 029000
QUARTER: 1
YEAR: 2019

Certified With Comments

This data is submitted in an effort to meet statutory requirements. Conclusions drawn could be erroneous due to communication difficulties in reporting complete data caused by reporting constraints, subjectivity in assignment of codes, various system mapping and normal clerical error. Data submission deadlines prevent inclusion of all applicable cases therefore this represents administrative claims data at the time of preset deadlines. Diagnostic and procedural data may be incomplete due to data field limitations. Data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: CHI St Joseph Health Madison Hospital
THCIC ID: 041000

QUARTER: 1
YEAR: 2019

Certified With Comments

Two claims had reported errors, one for invalid zip code, another for a claim indicator code for a single payor., both of which do not have an impact on any clinical reporting.

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PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
QUARTER: 1
YEAR: 2019

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of November 15, 2019. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC rules. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgments about patient care.

Submission Timing

To meet the States submission deadline, approximately 30 days following the close of the calendar year quarter, we submit a snapshot of billed claims, extracted from our database. Any discharged patient encounters no billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed which can alter the true picture of a patient's hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a ICD-10-CM effective 10-1-2015. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-10-CM is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore, mortality ratios may be accurate for reporting

standards but overstated.
Physician
While the hospital documents many treating physicians for each case, the THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians. Many physicians provide care to patients throughout a hospital stay. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Analysis of "Other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.
One account with DRG 794 was associated with a physician who entered an emergent order. After the THCIC cutoff for corrections period it was discovered the correct attending physician had not updated.
Due to hospital volumes, it is not feasible to perform encounter level audits and edits. All known errors have been corrected to the best of our knowledge. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: San Angelo Community Medical Center
THCIC ID: 056000
QUARTER: 1
YEAR: 2019

Certified With Comments

I corrected all that I was able to correct.

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PROVIDER: Goodall - Witcher Hospital
THCIC ID: 070000
QUARTER: 1
YEAR: 2019

Certified With Comments

Race collection issues are being addressed and corrected.

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PROVIDER: Mission Trail Baptist Hospital
THCIC ID: 081001
QUARTER: 1
YEAR: 2019

Certified With Comments

1Q 2019 Inpatient certified by Jennifer Bazar Gomez

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PROVIDER: Wilbarger General Hospital
THCIC ID: 084000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Any correction needed has been completed.

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PROVIDER: Hunt Regional Medical Center Greenville
THCIC ID: 085000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Q1 IP, Other Procedure Date error (#617)-Patients were presented as OP, had subsequent surgery and required inpatient care postoperatevely.

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PROVIDER: Montgomery County Mental Health Treatment Facility
THCIC ID: 100087
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Total claims for 1st Quarter (97) + (1) Claim [#2018-01] from 4th Qtr data

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PROVIDER: Baptist Medical Center
THCIC ID: 114001
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Q1 2019 Certified by Jennifer Bazar Gomez

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PROVIDER: CHI St Lukes Health Baylor College of Medicine Medical Center
THCIC ID: 118000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The data reports for Quarter 1, 2019 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-10-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

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PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

This data represents accurate information at the time of submission. Subsequent changes may continue to occur that will not be reflected in this published dataset.

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PROVIDER: University Hospital
THCIC ID: 158000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

University Hospital provides healthcare to a large population in Bexar county and other surrounded counties.
IP claim accuracy rate is 99.79% for Q1 2019.
OP claim accuracy rate is 99.58% for Q1 2019.
Data submitted by this facility has been corrected to the best of our ability to meet State requirements.

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PROVIDER: Cochran Memorial Hospital
THCIC ID: 159000
QUARTER: 1
YEAR: 2019

Certified With Comments

one claim was unbillable
also learned today that claims that can not be corrected may be deleted to increase accuracy

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PROVIDER: Las Palmas Medical Center
THCIC ID: 180000
QUARTER: 1
YEAR: 2019

Certified With Comments

This data is submitted as a best effort to meet statutory requirements. It is administrative data not clinical data and is utilized for billing and planning purposes. Conclusions drawn could be erroneous due to reporting constraints, subjectivity in assignment of codes, system mapping and normal clerical error. Diagnostic and procedural data may be incomplete due to data field limitations. The State data file may not fully represent all diagnoses treated or all procedures performed. Race and ethnicity data may be subjectively collected and may not provide an accurate representation of the patient population for a facility. It should also be noted that charges are not equal to actual payments received by the facility or facility costs for performing the service. Most errors occuring are due to incorrect country codes or zip codes assigned to foreign coutries which are not recognized in the correction software. These have been corrected to the best of my ability and resources. Also in this quarter were errors pretaining to the assignment of codes which were corrected by coders after the submission of data to the State and admission diagnosis that were missing which were present or corrected.

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PROVIDER: Medical Center Hospital
THCIC ID: 181000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

certify

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Data Content This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization.

For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
09/26/19 4
Admit Source data for Normal Newborn When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that

this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: CHRISTUS Spohn Hospital-Kleberg
THCIC ID: 216001
QUARTER: 1
YEAR: 2019

Certified With Comments

Done

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical

details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker

patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
09/26/19 4
Admit Source data for Normal Newborn When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Fort Worth recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Discharge Disposition THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Wise Health System
THCIC ID: 254000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The data for 1Q2019 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

Any claims errors generated for missing information for the Operating Physician or Invalid Value Codes are caused by system issue which did not affect the quality or accuracy of the claim data as it has been accepted and processed by the payer for reimbursement when appropriate.

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PROVIDER: Wise Health System
THCIC ID: 254001
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The data for 1Q2019 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

Any claims errors generated for missing information for the Operating Physician or Invalid Value Codes are caused by system issue which did not affect the quality or accuracy of the claim data as it has been accepted and processed by the payer for reimbursement when appropriate.

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PROVIDER: Texas Health Harris Methodist Hospital-Stephenville

THCIC ID: 256000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
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Diagnosis and Procedures Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
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09/26/19 4
Admit Source data for Normal Newborn When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Stephenville recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
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care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
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Discharge Disposition THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 1
YEAR: 2019

Certified With Comments

In this database only one primary physician is allowed. This represents the physician at discharge in this institution. At an academic medical center such as University Medical Center of El Paso, patients are cared for by teams of physicians who rotate at varying intervals. Therefore, many patients, particularly long term patients may actually be managed by several different teams. The practice of attributing patient outcomes in the database to a single physician may result in inaccurate information.

Through performance improvement process, we review the data and strive to make changes to result in improvement.

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PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data

elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay The length of stay data element contained in the states

certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
09/26/19 4
Admit Source data for Normal Newborn When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Kaufman recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Valley Baptist Medical Center-Brownsville
THCIC ID: 314001
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Ceritification of Q1 IP

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PROVIDER: Del Sol Medical Center
THCIC ID: 319000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

This data is submitted in an effort to meet statutory requirements. It is administrative data not clerical data and is utilize for billing purposes. Conclusions drawn could be erroneous due to reporting constraints, subjectivity in assignment of codes, system mapping and normal clerical error. Diagnostic and procedural data may be incomplete due to data field limitations. The State data file may not fully represent all diagnoses treated or all procedures performed. Race and ethnicity data may be subjectively collected and may not provide an accurate representation of the patient population for a facility. It should also be noted that changes are not equal to actual payments received by the facility or facility costs for performing the service. Most errors occurring are due to incorrect country codes or zip codes assigned to foreign countries, which are not recognized in the correction software. Corrections to coding data are made after coding audits by coding experts and are present after initial data is submitted to the State. All data has been corrected to the best of my ability and resources.

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Data Content This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical

details of an encounter. The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume. Diagnosis and Procedures Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance. The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates. The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker

patients, are likewise less accurately reflected. Length of Stay The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
09/26/19 4
Admit Source data for Normal Newborn When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Cleburne recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission. Race/Ethnicity As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility. Standard/Non-Standard Source of Payment The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis. Cost/ Revenue Codes The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs. Discharge Disposition THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

BUMC 331000
1st QTR 2019

Certification Comment:

Three encounters with the 803 warning consist of data from near duplicate claims where only one claim contained the correct data, and the duplicates could not be removed from the data.

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PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Cook Children's Medical Center has submitted and certified FIRST QUARTER 2019 inpatient, outpatient surgery and outpatient radiology encounters to the Texas Health Care Information Council with the following possible data concerns based on the required submission method.

Since our data was submitted to the State we have uncovered medical coding errors regarding the following patient conditions in 2005 and 2010 discharges:

Post-operative infections
Accidental puncture and lacerations
Post-operative wound dehiscence
Post-operative hemorrhage and hematoma

Comparative complication reports reflecting the above conditions could misstate the true conditions at Cook Children's Medical Center for the FIRST QUARTER OF 2019.

There may be some encounters will have one of the following issues:

Questionable Revenue Procedure Modifier 1
Questionable Revenue Procedure Modifier 2
Missing either a THCIC required HCPCS code, or not having a THCIC required revenue code and contain at least one procedure code.

These are errors that are very difficult, if not impossible to correct as that is how they are sent to the respective payers. This is especially true for modifier errors related to transport (especially our fixed wing transport. Per the following website, these modifiers appear to be legitimate: https://www.findacode.com/code-set.php?set=HCPCSMODA.
Additionally, there may be outpatient encounters where there is an invalid NPI associated with the attending provider. These are most likely to be encounters in the ED where a patient was seen by a nurse in triage and charges were incurred, but left without being seen by a physician or an advanced nurse provider.

However, our overall accuracy rate is very high, so this will be a small proportion of our encounters.
We will continue to work with the Revenue Cycle team to improve the accuracy of the data elements going forward.

This will affect encounters for the FIRST QUARTER OF 2019

Patient charges that were accrued before admit or after discharge were systematically excluded from the database. This can happen when a patient is pre-admitted and incurs charges to their encounter before their admit date or charges are discovered and added to the patient encounter after they are discharged. Therefore, the charges for many patient encounters are under reported.

The data structure allowed by THCIC erroneously assigns surgeons to surgical procedures they did not perform. The data structure provided by THCIC allows for one attending and one operating physician assignment. However, patients frequently undergo multiple surgeries where different physicians perform multiple procedures. Assigning all of those procedures to a single 'operating physician' will frequently attribute surgeries to the wrong physician. THCIC chooses to only assign one surgeon to a patient encounter, not to each procedure.

Furthermore, the data structure established by THCIC allows for a limited number of diagnoses and procedures. Patients with more than the limit for diagnoses or procedures will be missing information from the database. This is especially true in complex cases where a patient has multiple major illnesses and multiple surgeries over an extended stay.

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PROVIDER: Medical Arts Hospital

THCIC ID: 341000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Due to the sheer volume of the data and with limited resources within the hospital, I cannot properly analyze the data with 100% accuracy. But at this time we will elect to certify the data.

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PROVIDER: Coryell Memorial Hospital
THCIC ID: 346000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Coryell Health had 203 inpatient discharges during Q1 2019 even though only 166 cases are reported.

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PROVIDER: Reeves County Hospital
THCIC ID: 367000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

We were going through staff changes and an EMR transition due to not getting the chance for corrections

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PROVIDER: Nacogdoches Medical Center
THCIC ID: 392000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

reviewed and updated .

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PROVIDER: CHRISTUS Spohn Hospital Corpus Christi

THCIC ID: 398000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Done

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PROVIDER: CHRISTUS Spohn Hospital Corpus Christi-Shoreline
THCIC ID: 398001
 QUARTER: 1
    YEAR: 2019

Certified With Comments

done

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PROVIDER: Valley Baptist Medical Center
THCIC ID: 400000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Certification of Q1 2019

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

John Peter Smith Hospital (JPSH) is operated by JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission. In addition, JPSH holds Joint Commission accreditation as a hospital.

JPSH is the only Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only psychiatric emergency center in the county. The hospital's services include intensive care for adults and newborns, an AIDS treatment center, a full range of obstetrical and gynecological services, adult

inpatient care and an inpatient mental health treatment facility.

JPSH is a major teaching hospital offering, or providing through co-operative arrangements, postdoctoral training in orthopedics, obstetrics and gynecology, psychiatry, surgery, oral and maxillofacial surgery, radiology, sports medicine, podiatry and pharmacy. The family medicine residency is the largest hospital-based family medicine residency program in the nation.

In addition to JPSH, the JPS Health Network operates community health centers located in medically underserved areas of Tarrant County; school-based health clinics; outpatient programs for pregnant women, behavioral health and cancer patients; and a wide range of wellness education programs.

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
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The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An

apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
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If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
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The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: CHRISTUS Spohn Hospital-Beeville
THCIC ID: 429001
QUARTER: 1
YEAR: 2019

Certified With Comments

Done

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 1

YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
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and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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Admit Source data for Normal Newborn

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If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
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==========
PROVIDER: UT Southwestern University Hospital-Clements University
THCIC ID: 448001
 QUARTER: 1
    YEAR: 2019

Certified With Comments

E-617 & E-618 - The procedure dates on these accounts are correct - Unable to resolve

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PROVIDER: Dallas Medical Center
THCIC ID: 449000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

certify Q1 ip

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PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The DeTar Healthcare System includes two full-service acute care hospitals: DeTar Hospital Navarro located at 506 E. San Antonio Street and DeTar Hospital

North located at 101 Medical Drive. Both acute care hospitals are located in Victoria, Texas. DeTar Healthcare System is both Joint Commission accredited and Medicare certified. The system also includes two Emergency Departments with Level III Trauma Designation at DeTar Hospital Navarro and Level IV Trauma Designation at DeTar Hospital North; DeTar Health and Fitness Center; a comprehensive Cardiac Program including Cardiothoracic Surgery and Interventional Cardiology as well as Electrophysiology; Interventional Radiology Services; Accredited Chest Pain Center; a Bariatric Surgery Center of Excellence, Inpatient and Outpatient Rehabilitation Centers; DeTar Senior Care Center; Infusion Center; DeTar on Demand Urgent Care Centers, Primary Stroke Center, DeTar Family Medicine Residency program, and a free Physician Referral Call Center. To learn more, please visit our website at www.detar.com.

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PROVIDER: DeTar Hospital-North
THCIC ID: 453001
QUARTER: 1
YEAR: 2019

Certified With Comments

The DeTar Healthcare System includes two full-service acute care hospitals: DeTar Hospital Navarro located at 506 E. San Antonio Street and DeTar Hospital North located at 101 Medical Drive. Both acute care hospitals are located in Victoria, Texas. DeTar Healthcare System is both Joint Commission accredited and Medicare certified. The system also includes two Emergency Departments with Level III Trauma Designation at DeTar Hospital Navarro and Level IV Trauma Designation at DeTar Hospital North; DeTar Health and Fitness Center; a comprehensive Cardiac Program including Cardiothoracic Surgery and Interventional Cardiology as well as Electrophysiology; Interventional Radiology Services; Accredited Chest Pain Center; a Bariatric Surgery Center of Excellence, Inpatient and Outpatient Rehabilitation Centers; DeTar Senior Care Center; Infusion Center; DeTar on Demand Urgent Care Centers, Primary Stroke Center, DeTar Family Medicine Residency program, and a free Physician Referral Call Center. To learn more, please visit our website at www.detar.com.

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PROVIDER: Medical Center-Southeast Texas
THCIC ID: 464002
QUARTER: 1
YEAR: 2019

Certified With Comments

Claim errors are a result of an inssue with the EMR. The issue looks to not be present in next quarter's data.

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PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all

procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Memorial Medical Center
THCIC ID: 487000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

All inpatients have been corrected

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PROVIDER: Driscoll Childrens Hospital
THCIC ID: 488000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

All provider identifying information has been verified and will be updated against a reference file and continues to be reviewed on an ongoing basis.

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PROVIDER: Ascension Seton Medical Center
THCIC ID: 497000
 QUARTER: 1

YEAR: 2019

Certified With Comments

Seton Medical Center Austin has a transplant program and Neonatal Intensive Care Unit (NICU). Hospitals with transplant programs generally serve a more seriously ill patient, increasing costs and mortality rates. The NICU serves very seriously ill infants substantially increasing cost, lengths of stay and mortality rates. As a regional referral center and tertiary care hospital for cardiac and critical care services, Seton Medical Center Austin receives numerous transfers from hospitals not able to serve a more complex mix of patients. This increased patient complexity may lead to longer lengths of stay, higher costs and increased mortality.

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: St Lukes Baptist Hospital
THCIC ID: 503001
QUARTER: 1
YEAR: 2019

Certified With Comments

Certifed by Felicia A. Rodriguez, Director of Revenue Analysis fon behalf of Geoff Vines- CFO, St. Luke's Baptist Hospital. phone: (210) 297-5350.

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PROVIDER: Seymour Hospital
THCIC ID: 546000
QUARTER: 1
YEAR: 2019

Certified With Comments

Due to staff turnover with the THCIC claim corrector, 1st quarter of 2019 was missed. We had been at 100% until this quarter. Most of the errors we correct are SS numbers. Many undocumented immigrants we serve and newborns delivered at our hospital have no SS number. Once the parents receive the newborns SS number, they frequently do not forward this information to us even after several futile attempts.

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PROVIDER: Ascension Seton Highland Lakes
THCIC ID: 559000
QUARTER: 1
YEAR: 2019

Certified With Comments

Seton Highland Lakes, a member of the Seton Family of Hospitals, is a 25-bed acute care facility located between Burnet and Marble Falls on Highway 281. The hospital offers 24-hour emergency services, plus comprehensive diagnostic and treatment services for residents in the surrounding area. Seton Highland Lakes also offers home health and hospice services. For primary and preventive care, Seton Highland Lakes offers a clinic in Burnet, a clinic in Marble Falls, a clinic in Bertram, a clinic in Lampasas, and a pediatric mobile clinic in the county. This facility is designated by the Center for Medicare & Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations under its Critical Access designation program.

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Ascension Seton Edgar B Davis
THCIC ID: 597000
QUARTER: 1
YEAR: 2019

Certified With Comments

Seton Edgar B. Davis, a member of the Seton Family of Hospitals, is a general acute care, 25-bed facility committed to providing quality inpatient and outpatient services for residents of Caldwell and surrounding counties. Seton Edgar B. Davis offers health education and wellness programs. In addition, specialists offer a number of outpatient specialty clinics providing area residents local access to the services of medical specialists. Seton Edgar B. Davis is located at 130 Hays St. in Luling, Texas. This facility is designated by the Center for Medicare & Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations under its Critical Access program.

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
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The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always

possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been

added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Hamilton General Hospital
THCIC ID: 640000
QUARTER: 1
YEAR: 2019

Certified With Comments

Submission includes all data available at time of reporting.

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PROVIDER: Kindred Hospital-San Antonio
THCIC ID: 645000
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 84 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the

patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
Texas Health Specialty Hospital does not have a newborn population.

Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing

record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: UT Southwestern University Hospital-Zale Lipshy
THCIC ID: 653001
 QUARTER: 1
    YEAR: 2019

Certified With Comments

E-617 & E-618 - The procedure dates on these accounts are correct, unable to resolve errors

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PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 105 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Data Content
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The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all

procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
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Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========
PROVIDER: Kindred Hospital-Houston Medical Center
THCIC ID: 676000
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 204 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Kindred Rehab Hospital Clear Lake
THCIC ID: 680000
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a rehab care hospital that provides an acute hospital level of care and services to patient requiring rehab care hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 203 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: CHRISTUS Spohn Hospital Alice
THCIC ID: 689401
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Done

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PROVIDER: Kindred Hospital-Tarrant County
THCIC ID: 690000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 71 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

==========
PROVIDER: Kindred Hospital Houston NW
THCIC ID: 706000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 139 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: CHRISTUS St Michael Rehab Hospital
THCIC ID: 713001
QUARTER: 1
YEAR: 2019

Certified With Comments

I approve to be certified.

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PROVIDER: Texas Health Seay Behavioral Health Hospital
THCIC ID: 720000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
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hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at

discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Kindred Hospital Clear Lake
THCIC ID: 720402
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 177 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain

an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Kindred Hospital El Paso
THCIC ID: 727100
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 129 records are correctly reported.

Ernestine Marsh

Kindred Healthcare

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PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
QUARTER: 1
YEAR: 2019

Certified With Comments

THHV - Inpatient

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a
standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume. The current data in this submission will exclude much of the March data due to issues with software, vendor and process changes. These issues have been resolved and the excluded data will be submitted with the next data submission.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always

possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are

categorized as Commercial PPO. Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

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PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
QUARTER: 1
YEAR: 2019

Certified With Comments

The data reports for Quarter 1, 2019 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-10-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

==========
PROVIDER: Texas Health Springwood Behavioral Health Hospital
THCIC ID: 778000
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an

encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker

patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and

denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: South Texas Spine & Surgical Hospital
THCIC ID: 786800
QUARTER: 1
YEAR: 2019

Certified With Comments

certify without comments

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PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
QUARTER: 1
YEAR: 2019

Certified With Comments

I approve to be certified.

==========
PROVIDER: Christus St Michael Hospital Atlanta
THCIC ID: 788003
QUARTER: 1
YEAR: 2019

Certified With Comments

I approve to be certified.

==========
PROVIDER: Kindred Hospital Spring
THCIC ID: 792600
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 148 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Kindred Hospital Tomball
THCIC ID: 792601
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 100 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Kindred Hospital Sugar Land
THCIC ID: 792700
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 231 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The data reports for Quarter 1, 2019 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-10-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

==========
PROVIDER: Ascension Seton Southwest
THCIC ID: 797500
 QUARTER: 1
    YEAR: 2019

Certified With Comments

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements

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PROVIDER: Ascension Seton Northwest
THCIC ID: 797600
 QUARTER: 1

YEAR: 2019

Certified With Comments

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Kindred Hospital Tarrant County Fort Worth SW
THCIC ID: 800000
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 206 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Kindred Hospital-Fort Worth
THCIC ID: 800700
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 128 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: Kindred Hospital Bay Area
THCIC ID: 801000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 159 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

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PROVIDER: East El Paso Physicians Medical Center
THCIC ID: 801300
 QUARTER: 1
    YEAR: 2019

Certified With Comments

overall volume was down for this quarter compared to previous quarters

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PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The Q1 2019 All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

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PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
 QUARTER: 1

YEAR: 2019

Certified With Comments

The Q1 2019 All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

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PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
QUARTER: 1
YEAR: 2019

Certified With Comments

The Q1 2019 All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

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PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes,

however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========
PROVIDER: Westlake Medical Center
THCIC ID: 822800
QUARTER: 1
YEAR: 2019

Certified With Comments

Gender transformation procedures both male to female and femal to male performed

during same operative session

==========
PROVIDER: Hickory Trail Hospital
THCIC ID: 837800
 QUARTER: 1
    YEAR: 2019

Certified With Comments

certified for Hickory Trail Hospital Admin

==========
PROVIDER: El Paso LTAC Hospital
THCIC ID: 841300
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Certify 2019 1Q Inpatient 54 encounters without comments. Thank You!

==========
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Dell Children's Medical Center of Central Texas (DCMCCT) is the only children's hospital in the Central Texas Region. DCMCCT serves severely ill and/or injured children requiring intensive resources which increase the hospital's costs of care, lengths of stay and mortality rates. In addition, the hospital includes a Neonatal Intensive Care Unit (NICU) which serves very
seriously ill infants, which substantially increases costs of care, lengths of stay and mortality rates.

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements

==========
PROVIDER: Physicians Surgical Hospital-Quail Creek
THCIC ID: 852900
 QUARTER: 1
    YEAR: 2019

Certified With Comments

All data correct to my knowledge

==========
PROVIDER: Physicians Surgical Hospital-Panhandle Campus
THCIC ID: 852901
 QUARTER: 1
    YEAR: 2019

Certified With Comments

All data is correct to my knowledge

==========
PROVIDER: Central Texas Rehab Hospital
THCIC ID: 854400
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a rehab care hospital that provides an acute hospital level of care and services to patient requiring a rehab care hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 233 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

==========
PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The Q1 2019 All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

==========

PROVIDER: Ascension Seton Williamson
THCIC ID: 861700
 QUARTER: 1
    YEAR: 2019

Certified With Comments

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

==========

PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The data reports for Quarter 1, 2019 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-10-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

==========

PROVIDER: Kindred Hospital Dallas Central
THCIC ID: 914000
QUARTER: 1
YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 139 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

==========

PROVIDER: Ascension Seton Hays
THCIC ID: 921000
QUARTER: 1
YEAR: 2019

Certified With Comments

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

==========

PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 1
YEAR: 2019

Certified With Comments

The data reports for Quarter 1, 2019 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-10-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

==========

PROVIDER: Kindred Hospital The Heights
THCIC ID: 941000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 142 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

==========

PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
 QUARTER: 1
    YEAR: 2019

Certified With Comments

The Q1 2019 All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

==========

PROVIDER: Kindred Rehab Hospital Northeast Houston
THCIC ID: 969600
 QUARTER: 1

YEAR: 2019

Certified With Comments

Kindred Hospital is a rehab care hospital that provides an acute hospital level of care and services to patient requiring rehab care hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 166 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

==========

PROVIDER: Seton Medical Center Harker Heights
THCIC ID: 971000
QUARTER: 1
YEAR: 2019

Certified With Comments

I am certifying that these inpatient accounts are correct to the best of my knowledge.

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PROVIDER: Texas Health Harris Methodist Hospital Alliance
THCIC ID: 972900
QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

The length of stay data element contained in the states certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========

PROVIDER: Mesa Springs
THCIC ID: 973430
QUARTER: 1
YEAR: 2019

Certified With Comments

The 1st Qtr, 2019 data for ethnicity is incorrect. We are working on our system to be able to accurately report this statistic.

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PROVIDER: Wise Health Surgical Hospital
THCIC ID: 973840
QUARTER: 1
YEAR: 2019

Certified With Comments

The data for 1Q2019 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

Any claims errors generated for missing information for the Operating Physician or Invalid Value Codes are caused by system issue which did not affect the quality or accuracy of the claim data as it has been accepted and processed by the payer for reimbursement when appropriate.

==========

PROVIDER: Woodlands Specialty Hospital
THCIC ID: 974150
QUARTER: 1
YEAR: 2019

Certified With Comments

Athena EMR systems unable to generate an accurate report. We have communicated extensively with Athena. At this time, to the best of our knowledge the problem has been resolved.

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PROVIDER: Texas Rehab Hospital of Arlington
THCIC ID: 974730
QUARTER: 1

YEAR: 2019

Certified With Comments

Errors fixed. No issues.

==========

PROVIDER: JPS Health Network - Trinity Springs North
THCIC ID: 975121
QUARTER: 1
YEAR: 2019

Certified With Comments

John Peter Smith Hospital (JPSH) is operated by JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission. In addition, JPSH holds Joint Commission accreditation as a hospital.

JPSH is the only Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only psychiatric emergency center in the county. The hospital's services include intensive care for adults and newborns, an AIDS treatment center, a full range of obstetrical and gynecological services, adult inpatient care and an inpatient mental health treatment facility.

JPSH is a major teaching hospital offering, or providing through co-operative arrangements, postdoctoral training in orthopedics, obstetrics and gynecology, psychiatry, surgery, oral and maxillofacial surgery, radiology, sports medicine, podiatry and pharmacy. The family medicine residency is the largest hospital-based family medicine residency program in the nation.

In addition to JPSH, the JPS Health Network operates community health centers located in medically underserved areas of Tarrant County; school-based health clinics; outpatient programs for pregnant women, behavioral health and cancer patients; and a wide range of wellness education programs.

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PROVIDER: First Baptist Medical Center
THCIC ID: 975129
QUARTER: 1
YEAR: 2019

Certified With Comments

Some of the errors were due to zip code (out of country residents) , charges have the exact DOS updated to it and CPT code 30617 (scd sleeve large code

invalid).

==========
PROVIDER: Providence Hospital of North Houston
THCIC ID: 975152
 QUARTER: 1
    YEAR: 2019

Certified With Comments

remaining errors are for missing POA values and invalid diagnosis codes.
Facility failed to make correction by required timeline.

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PROVIDER: Methodist Southlake Hospital
THCIC ID: 975153
 QUARTER: 1
    YEAR: 2019

Certified With Comments

No comments

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PROVIDER: Kindred Hospital San Antonio Central
THCIC ID: 975155
 QUARTER: 1
    YEAR: 2019

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 81 records are correctly reported.

Ernestine Marsh
Kindred Healthcare

==========
PROVIDER: Texas Health Hospital Clearfork
THCIC ID: 975167

QUARTER: 1
YEAR: 2019

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us

to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Arlington Memorial Hospital recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information,

because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
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Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to home as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========
PROVIDER: Dell Seton Medical Center at The University of Texas
THCIC ID: 975215
QUARTER: 1
YEAR: 2019

Certified With Comments

As the public teaching hospital in Austin and Travis County, Dell Seton Medical Center at The University of Texas (DSMCUT) serves patients who are often unable to access primary care. It is more likely that these patients will present in the later more complex stage of their disease.

It is also a regional referral center, receiving patient transfers from hospitals not able to serve a complex mix of patients. Treatment of these very complex, seriously ill patients increases the hospital's cost of care, length of stay and mortality rates.

As the Regional Level I Trauma Center, DSMCUT serves severely injured patients. Lengths of stay and mortality rates are most appropriately compared to other trauma centers.

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

==========
PROVIDER: Encompass Health Rehab Hospital Pearland

THCIC ID: 975246
QUARTER: 1
YEAR: 2019

Certified With Comments

No comments

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PROVIDER: Wise Health Surgical Hospital
THCIC ID: 975322
QUARTER: 1
YEAR: 2019

Certified With Comments

The data for 1Q2019 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

Any claims errors generated for missing information for the Operating Physician or Invalid Value Codes are caused by system issue which did not affect the quality or accuracy of the claim data as it has been accepted and processed by the payer for reimbursement when appropriate.