

Outpatient Facility Comments, 4Q2012.txt

General Comments on 4th Quarter 2012 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 facility's standard data collection process, there may be an increase in the error rate for these elements.

. Facilities 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.

. Facilities are required to submit data within 60 days after the close of a calendar quarter (facility data submission vendor deadlines may be sooner). Depending on facilities' collection and billing cycles, not all services 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 facility 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 facilities as their best effort to meet statutory requirements.

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PROVIDER: Parkland Memorial Hospital  
THCIC ID: 474000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a \$995 million enterprise that is licensed for 968 beds and employs approximately 9,474 staff. 86,051 patients received outpatient care in the clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

As in other large academic medical centers, teams of physicians rotating at intervals care for patients. The THCIC dataset allows only one primary physician to be assigned to the patient for the entire inpatient stay. In our institution, this represents the physician caring for the patient at the time of discharge. Many patients, particularly long-term care patients are actually managed by as many as three to four different teams and attending physicians. For this reason, the practice of attributing patient outcomes to the report card of a single physician may result in misleading information.

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PROVIDER: St Joseph Regional Health Center  
THCIC ID: 002001  
QUARTER: 4  
YEAR: 2012

Certified With Comments

St Joseph Regional Health Center uses TX 5200 format to do outpatient data submission through its vendor Truven Health (<http://truvenhealth.com/>), formerly Thomson Reuters.

Currently THCIC only requires hospitals to submit outpatient records who received one or more of the surgical procedures and/or radiological services covered by some specific revenue codes. St Joseph Regional Health Center submits more than required outpatient discharges to Thomson Reuters, who then converts the submitted outpatient records to 837 format and sends all submitted outpatient records to THCIC data warehouse System 13 Inc (<https://thcic.system13.com>). Unwanted outpatient records, defined as those records containing non reportable revenue codes, are dropped by System 13, Inc. User discretion is advised in using outpatient data for analysis purposes.

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PROVIDER: Matagorda Regional Medical Center  
THCIC ID: 006000  
QUARTER: 4  
YEAR: 2012

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: Good Shepherd Medical Center-Marshall  
THCIC ID: 020000  
QUARTER: 4  
YEAR: 2012

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: Baylor Medical Center-Garland  
THCIC ID: 027000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to

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analyze the data. Regarding the mandate to communicate the Certification reports to physicians The State does not offer a secure mechanism for us to communicate other than the hard copy reports. At this time, we as a hospital are moving to limit or eliminate paper distribution and we do not have an internal system to communicate to all physicians feasibly.

Quality Trending of data over a few years is important to define outcome and quality. A small sampling of data (i.e. one year) does not explain outcome.

We recommend the Patient communicate with the Hospital and the Physician regarding data. Patient and physician preference contributes to the care rendered to the patient and the data does not always reflect this.

Patients and physicians consider many factors when making health care decisions that are not available in administrative data. These include a patients preference for life-sustaining treatments, functional status, and other factors.

We support the Patient, Provider, and Payer and empowered, educated decision-making. Quality improvement is not new; it is an on-going commitment.

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PROVIDER: Kindred Hospital -Dallas
THCIC ID: 028000
QUARTER: 4
YEAR: 2012

Certified With Comments

Claims are being submitted with revenue codes does not meet criteria errors, per THCIC reps

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PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
QUARTER: 4
YEAR: 2012

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: Madison St Joseph Health Center
THCIC ID: 041000
QUARTER: 4
YEAR: 2012

Certified With Comments

Madison St. Joseph Hospital uses TX 5200 format to do outpatient data submission

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through its vendor Truven Health (<http://truvenhealth.com/>), formerly Thomson Reuters.

Currently THCIC only requires hospitals to submit outpatient records who received one or more of the surgical procedures and/or radiological services covered by some specific revenue codes. Madison St. Joseph Hospital submits more than required outpatient discharges to Thomson Reuters, who then converts the submitted outpatient records to 837 format and sends all submitted outpatient records to THCIC data warehouse System 13 Inc (<https://thcic.system13.com>). Unwanted outpatient records, defined as those records containing non reportable revenue codes, are dropped by System 13, Inc. User discretion is advised in using outpatient data for analysis purposes.

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PROVIDER: Baylor Medical Center at Carrollton  
THCIC ID: 042000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Baylor Medical Center Carrollton OUTPATIENT DATA  
THCIC ID: 042000  
QUARTER: 4  
YEAR: 2012

CERTIFIED WITH COMMENTS

Due to the sheer volume of OP data, we have limited resources as a hospital to analyze the data. Regarding the mandate to communicate the Certification reports to physicians The State does not offer a secure mechanism for us to communicate other than the hard copy reports. At this time, we as a hospital are moving to limit or eliminate paper distribution and we do not have an internal system to communicate to all physicians feasibly.

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PROVIDER: Huguley Memorial Medical Center  
THCIC ID: 047000  
QUARTER: 4  
YEAR: 2012

Elected Not to Certify

THCIC 3rd Quarter 2012 Huguley Memorial Medical Center Outpatient Comments  
Elected not to Certify

Due to the notification from THCIC, October 29, 2012 the THCIC Outpatient Technical Specification Manual was previously incorrect and specific revenue codes were unintentionally omitted from the manual, the Huguley Memorial Medical Center Outpatient dataset may have discharges included from a prior Certification quarter. THCIC merged the missing patient encounters back into the correct quarterly dataset. If the user of this dataset is able to filter the 3rd quarter discharges from this dataset, the data should be accurate. The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of June 1, 2013. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC. 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

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not 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 ICD-9-CM and CPT. 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-9-CM and CPT 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.

Given the current certification software, due to hospital volumes, it is not feasible to perform encounter level audits and edits. To meet the state's mandates to submit hospital Outpatient visits with specific procedures, Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format.

All known errors have been corrected to the best of our knowledge. Due to the issues with discharges being merged between multiple quarters at THCIC, we chose not to certify the data for this quarter. However, the quarterly data to the best of our knowledge is accurate and complete given the above.

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PROVIDER: San Angelo Community Medical Center  
THCIC ID: 056000  
QUARTER: 4  
YEAR: 2012

Elected Not to Certify

Not reviewed by physicians after submitted to THCIC.

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PROVIDER: Hunt Regional Medical Center Greenville  
THCIC ID: 085000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

DFWHC has had to resend several QTRS to THCIC because of errors in processing.

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PROVIDER: Hunt Regional Community Hospital  
THCIC ID: 087000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

DFWHC has had to resend several QTRS to THCIC because of errors in processing.

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PROVIDER: St Lukes Episcopal Hospital  
THCIC ID: 118000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

The data reports for Quarter 4, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system. 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: Wadley Regional Medical Center  
THCIC ID: 144000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Demographic information for this time period is incorrect. Due to a file conversion issue with our EMR system, McKesson, White/Caucasian race codes on the hospital side have been converted to American Indian with the file transfer to the THCIC database. Corporate IT is working with McKesson to correct this issue going forward.

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PROVIDER: University Medical Center  
THCIC ID: 145000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

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

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PROVIDER: Texas Health Harris Methodist HEB  
THCIC ID: 182000  
QUARTER: 4  
YEAR: 2012

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 outpatient claims for patients that receive outpatient surgical or radiological services, 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 outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). 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

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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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

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: Laredo Medical Center  
THCIC ID: 207001  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Jim Veteto has recently left the Organization. The new Director is Iris B. Martinez who has certified the Data. In the process of Updating the Certifier name

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PROVIDER: Texas Health Harris Methodist Hospital -Fort Worth  
THCIC ID: 235000  
QUARTER: 4

YEAR: 2012

Certified With Comments

Data Content

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PROVIDER: Wise Regional Health System
THCIC ID: 254001
QUARTER: 4
YEAR: 2012

Certified With Comments

The data for 4Q2012 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 THCIC; any changes would be information collected or updated during the normal course of business.

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PROVIDER: Texas Health Harris Methodist Hospital -Stephenville
THCIC ID: 256000
QUARTER: 4
YEAR: 2012

Certified With Comments

Data Content

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PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 4
YEAR: 2012

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: Baylor Medical Center-Waxahatchie
THCIC ID: 285000
QUARTER: 4
YEAR: 2012

Certified With Comments

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PROVIDER: Mother Frances Hospital  
THCIC ID: 286000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Claims dated September 30, 2012 are included with Quarter 4 2012, due to system conversion constraints. Also due to system conversion, race & ethnicity are reported incorrectly for this quarter only.

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PROVIDER: Baylor Medical Center-Irving  
THCIC ID: 300000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

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PROVIDER: Texas Health Presbyterian Hospital -Kaufman  
THCIC ID: 303000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

DataContent

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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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

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

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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

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne  
THCIC ID: 323000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

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PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 4
YEAR: 2012

Certified With Comments

Baylor Medical Center at BUMC OUTPATIENT DATA
THCIC ID: 331000
QUARTER: 4
YEAR: 2012

CERTIFIED WITH COMMENTS

Due to the sheer volume of OP data, we have limited resources as a hospital to analyze the data. Regarding the mandate to communicate the Certification reports to physicians The State does not offer a secure mechanism for us to communicate other than the hard copy reports. At this time, we as a hospital are moving to limit or eliminate paper distribution and we do not have an internal system to communicate to all physicians feasibly.

Quality Trending of data over a few years is important to define outcome and quality. A small sampling of data (i.e. one year) does not explain outcome.

We recommend the Patient communicate with the Hospital and the Physician regarding data. Patient and physician preference contributes to the care rendered to the patient and the data does not always reflect this.

Patients and physicians consider many factors when making health care decisions that are not available in administrative data. These include a patients preference for life-sustaining treatments, functional status, and other factors.

We support the Patient, Provider, and Payer and empowered, educated decision-making. Quality improvement is not new; it is an on-going commitment.

=====
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 4
YEAR: 2012

Certified With Comments

Cook Children's Medical Center has submitted and certified 4th QUARTER 2012 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:

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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 4th QUARTER OF 2013.

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: University Medical Center-Brackenridge  
THCIC ID: 335000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

As the public teaching hospital in Austin and Travis County, University Medical Center Brackenridge (UMCB) 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.

UMCB has a perinatal program that serves a population that includes mothers with late or no prenatal care. 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 Trauma Center, UMCB 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.

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PROVIDER: Baylor All Saints Medical Center-Fort Worth  
THCIC ID: 363000  
QUARTER: 4  
YEAR: 2012

Elected Not to Certify

Due to the inconsistent counts of OP claims with reports and extensive monetary change, Keith Zellmer has chosen not to Certify this quarters data.

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PROVIDER: Little River Healthcare  
THCIC ID: 369000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Large number of missing SSN due to computer conversion. Working on a fix for next quarter.

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PROVIDER: John Peter Smith Hospital  
THCIC ID: 409000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Due to an Epic conversion Managed Medicare and Medicaid are classified as Commercial payers.

JPS Health Network  
Comments on THCIC Data Submission  
For  
4th Quarter 2012

Introduction

John Peter Smith Hospital (JPSH) is operated by the 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 was the first Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only 24-hour, seven-day a week psychiatric emergency center in the area. The hospital's special services include intensive care for adults and newborns, a special AIDS treatment center, a skilled nursing unit, a full-range of obstetrical and gynecological services, inpatient care for patients of all ages and an inpatient mental health treatment facility.

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

In addition to JPSH, the JPS Health Network operates community-based health

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centers located in medically underserved areas of Tarrant County, school-based health centers, special outpatient programs for pregnant women and a wide range of wellness education programs.

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PROVIDER: Texas Health Arlington Memorial Hospital  
THCIC ID: 422000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Data Content

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Diagnosis and Procedures

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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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Race/Ethnicity

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 4
YEAR: 2012

Certified With Comments

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PROVIDER: DeTar Hospital -Navarro  
THCIC ID: 453000  
QUARTER: 4  
YEAR: 2012

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 in Victoria, Texas. DeTar Healthcare System is both Joint Commission accredited and Medicare certified. The system also includes a Skilled Nursing Unit; two Emergency Departments with Level III Trauma Designation at DeTar Hospital Navarro and Level IV Trauma Designation at DeTar Hospital North; DeTar Health Center; a comprehensive Cardiology Program including Cardiothoracic Surgery; Accredited Chest Pain Center; Inpatient and Outpatient Rehabilitation Centers; an Inpatient Geriatric Mental Health Center; the DeTar SeniorCare Center; Senior Circle; Primary Stroke Center; and a free Physician Referral Call Center. To learn more, please visit our website at [www.detar.com](http://www.detar.com).

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PROVIDER: DeTar Hospital -North  
THCIC ID: 453001  
QUARTER: 4  
YEAR: 2012

Certified With Comments

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PROVIDER: Texas Health Harris Methodist Hospital Azle  
THCIC ID: 469000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

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=====
PROVIDER: Seton Medical Center
THCIC ID: 497000
QUARTER: 4
YEAR: 2012

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: Baylor Regional Medical Center-Grapevine
THCIC ID: 513000
QUARTER: 4

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YEAR: 2012

Certified With Comments

The outpatient data has issues. The stats are much higher than what I'm reporting. Even when I include the Quarter 2 Rev code 320 which was submitted late for Quarter 3, the numbers are still too high. I am very interested in completing the reconciliation once the detail patient data is available.

=====
PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
QUARTER: 4
YEAR: 2012

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 service. For primary and preventative care, Seton Highland Lakes offers clinics in Burnet, Marble Falls, Bertram, Lampasas and a pediatric mobile clinic in the county. This facility is designated by the Center for Medicare and Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organization under its Critical Access designation program.

=====
PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
QUARTER: 4
YEAR: 2012

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 national provider identifiers 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: Texas Health Harris Methodist Hospital -Southwest Fort Worth
THCIC ID: 627000
QUARTER: 4

YEAR: 2012

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 outpatient claims for patients that receive outpatient surgical or radiological services, 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 outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes (CPT Codes). 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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

Length of Stay

Outpatient Facility Comments, 4Q2012.txt

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.

=====
PROVIDER: Texas Health Presbyterian Hospital -Plano
THCIC ID: 664000
QUARTER: 4
YEAR: 2012

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 outpatient claims for patients that receive outpatient surgical or radiological services, 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 outpatient hospital stay are coded by the hospital using a universal standard called the International

#### Outpatient Facility Comments, 4Q2012.txt

Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). 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.

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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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

#### 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.

Outpatient Facility Comments, 4Q2012.txt

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.

=====

PROVIDER: Burlison St Joseph Health Center-Caldwell  
THCIC ID: 679000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Burlison St. Joseph Hospital Center uses TX 5200 format to do outpatient data submission through its vendor Truven Health (<http://truvenhealth.com/>), formerly Thomson Reuters. Currently THCIC only requires hospitals to submit outpatient records who received one or more of the surgical procedures and/or radiological services covered by some specific revenue codes. Burlison St. Joseph Hospital Center submits more than required outpatient discharges to Thomson Reuters, who then converts the submitted outpatient records to 837 format and sends all submitted outpatient records to THCIC data warehouse System 13 Inc (<https://thcic.system13.com>). Unwanted outpatient records, defined as those records containing non reportable revenue codes, are dropped by System 13, Inc. User discretion is advised in using outpatient data for analysis purposes.

=====

PROVIDER: Kindred Hospital Houston NW  
THCIC ID: 706000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Claims were submitted with revenue codes do not meet criteria errors. Per THCIC ok to submit

=====

PROVIDER: Ennis Regional Medical Center  
THCIC ID: 714500  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Due to technical issues, some data fields may contain errors.

=====

PROVIDER: Texas Health Presbyterian Hospital Allen  
THCIC ID: 724200  
QUARTER: 4  
YEAR: 2012

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 outpatient claims for patients that receive outpatient surgical or radiological services, 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 outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). 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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

Outpatient Facility Comments, 4Q2012.txt

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, 2011, 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.

=====

PROVIDER: Methodist Willowbrook Hospital  
THCIC ID: 724700  
QUARTER: 4  
YEAR: 2012

Certified With Comments

303 records errored out incorrectly and failed to be submitted

=====

PROVIDER: Mother Frances Hospital -Jacksonville  
THCIC ID: 725400  
QUARTER: 4  
YEAR: 2012

Outpatient Facility Comments, 4Q2012.txt

Certified With Comments

Claims dated September 30, 2012 are included with Quarter 4 2012, due to system conversion constraints. Also due to system conversion, race & ethnicity are reported incorrectly for this quarter only.

=====

PROVIDER: Grimes St Joseph Health Center  
THCIC ID: 728800  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Grimes St. Joseph Hospital uses TX 5200 format to do outpatient data submission through its vendor Truven Health (<http://truvenhealth.com/>), formerly Thomson Reuters. Currently THCIC only requires hospitals to submit outpatient records who received one or more of the surgical procedures and/or radiological services covered by some specific revenue codes. Grimes St. Joseph Hospital submits more than required outpatient discharges to Thomson Reuters, who then converts the submitted outpatient records to 837 format and sends all submitted outpatient records to THCIC data warehouse System 13 Inc (<https://thcic.system13.com>). Unwanted outpatient records, defined as those records containing non reportable revenue codes, are dropped by System 13, Inc.

=====

PROVIDER: Green Oaks Hospital  
THCIC ID: 766000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Certify data as is.

=====

PROVIDER: Baylor Heart & Vascular Center  
THCIC ID: 784400  
QUARTER: 4  
YEAR: 2012

Certified With Comments

The OP Discharges total appears materially low. But the distribution mixes (as above) all appear reasonable. Until a report is available from THCIC that gives a listing of the individual accounts included here we wont be to identify a common pattern causing the discrepancy. The discrepancy does not appear to be isolated to a single month, payer type, or anything else. It is spread uniformly across all the reported elements.

=====

PROVIDER: CHRISTUS St Michael Health System  
THCIC ID: 788001  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Outpatient Facility Comments, 4Q2012.txt

To the best of my knowledge.

=====

PROVIDER: Kindred Hospital Spring  
THCIC ID: 792600  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Have two claims with errors, per conversation with Tiffany Overton ok to submitted file with error

=====

PROVIDER: St Lukes The Woodlands Hospital  
THCIC ID: 793100  
QUARTER: 4  
YEAR: 2012

Certified With Comments

The data reports for Quarter 4, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

=====

PROVIDER: Seton Southwest Hospital  
THCIC ID: 797500  
QUARTER: 4  
YEAR: 2012

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: Seton Northwest Hospital  
THCIC ID: 797600  
QUARTER: 4

Outpatient Facility Comments, 4Q2012.txt

YEAR: 2012

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: Lubbock Heart Hospital
THCIC ID: 801500
QUARTER: 4
YEAR: 2012

Elected Not to Certify

This information is so voluminous that I cannot accurately assess the information for 100% accuracy.

=====
PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
QUARTER: 4
YEAR: 2012

Certified With Comments

Possible Duplicates because of DFWHC resubmission per THCIC

=====
PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
QUARTER: 4
YEAR: 2012

Certified With Comments

Possible duplicates or missing charges

=====
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
QUARTER: 4
YEAR: 2012

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to analyze the data. Regarding the mandate to communicate the Certification reports to physicians The State does not offer a secure mechanism for us to communicate other than the hard copy reports. At this time, we as a hospital are moving to limit or eliminate paper distribution and we do not have an internal system to communicate to all physicians feasibly.

Quality Trending of data over a few years is important to define outcome and quality. A small sampling of data (i.e. one year) does not explain outcome.

Outpatient Facility Comments, 4Q2012.txt

We recommend the Patient communicate with the Hospital and the Physician regarding data. Patient and physician preference contributes to the care rendered to the patient and the data does not always reflect this.

Patients and physicians consider many factors when making health care decisions that are not available in administrative data. These include a patient's preference for life-sustaining treatments, functional status, and other factors.

We support the Patient, Provider, and Payer and empowered, educated decision-making. Quality improvement is not new; it is an on-going commitment.

=====

PROVIDER: Texas Health Center-Diagnostics & Surgery Plano  
THCIC ID: 815300  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Possible Duplicates because of DFWHC resubmission per THCIC

=====

PROVIDER: Texas Health Presbyterian Hospital -Denton  
THCIC ID: 820800  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Data Content

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Diagnosis and Procedures

Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). 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

Outpatient Facility Comments, 4Q2012.txt

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.

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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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

Length of Stay

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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.

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Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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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.

=====
PROVIDER: Good Shepherd Medical Center-Linden
THCIC ID: 822100
QUARTER: 4

YEAR: 2012

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.

=====
PROVIDER: University General Hospital
THCIC ID: 840200
QUARTER: 4
YEAR: 2012

Certified With Comments

Certified

=====
PROVIDER: Texoma Medical Center
THCIC ID: 847000
QUARTER: 4
YEAR: 2012

Certified With Comments

Data Source. The source of this data, the electronic bill, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

\*The billing data file limits the diagnosis codes to 25 (principal plus 24 secondary diagnosis codes); the admission diagnosis and up to nine E-code fields.

\*The procedure codes are limited to 25 (principal plus 24 secondary).

\*The fewer the codes the less information is available to evaluate the patients outcomes and service utilization

\*The Hospital can only list 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

Payer Codes. The payer codes utilized in the THCIC data base were defined by the state. They are not utilizing the standard payer information from the claim.

Revenue Codes and Charges. Charges associated with the 1450 data do not represent actual payments or costs for services.

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patients age, sex, diagnosis codes, procedure codes, and discharge status.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.

\*Not all claims may have been billed at this time.

\*Internal data may be updated later and appear different than the data on the claim.

Outpatient Facility Comments, 4Q2012.txt

Unless the payment is impacted, the hospital does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====

PROVIDER: Dell Childrens Medical Center  
THCIC ID: 852000  
QUARTER: 4  
YEAR: 2012

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 increases 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: Ethicus Hospital DFW  
THCIC ID: 858200  
QUARTER: 4  
YEAR: 2012

Certified With Comments

The charges reflected in this report are incorrect due to a data entry error. Total charges for the quarter were 7,166.00. Ave charge was 3,583.00. Minimum charge was 515.00 and maximum charge was 6,651.00.

=====

PROVIDER: Texas Health Presbyterian Hospital -Rockwall  
THCIC ID: 859900  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Possible Duplicates because of DFWHC resubmission per THCIC

=====

PROVIDER: Seton Medical Center Williamson  
THCIC ID: 861700  
QUARTER: 4  
YEAR: 2012

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

Outpatient Facility Comments, 4Q2012.txt  
some remain unidentified in the THIC Practitioner Reference Files.

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

=====

PROVIDER: St Lukes Sugar Land Hospital  
THIC ID: 869700  
QUARTER: 4  
YEAR: 2012

Certified With Comments

The data reports for Quarter 4, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

=====

PROVIDER: San Antonio Eye Surgi center  
THIC ID: 118001  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Patient Glenda Armstrong's operating physician was David Abrams 1881654314, not Sue Crow 1386653442.

Patient Lilia Baker's operating physician was John Nicolau, 1982808937, not Aaron Erdmanczyk 1578562377.

=====

PROVIDER: DeHaven Surgical Center  
THIC ID: 228002  
QUARTER: 4  
YEAR: 2012

Certified With Comments

certified on 01-23-13 at 8:34

=====

PROVIDER: The Center for Sight  
THIC ID: 272000  
QUARTER: 4

Outpatient Facility Comments, 4Q2012.txt

YEAR: 2012

Certified With Comments

Patient Age Breakdown shows 4 patients less than 1 year of age. We do not perform surgery on patients less than 18. The date of service was entered into the date of birth field on 4 patients causing the age to be less than 1 year.

=====

PROVIDER: Heaton Laser & Surgery Center  
THCIC ID: 377002  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Administrative update noted

=====

PROVIDER: Victoria Surgery Center  
THCIC ID: 396003  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Date of Service was originally entered incorrectly on 2 injection procedures. This was later corrected but may not be reflected on the claim sent to THCIC. All other data should be correct.

Thank you.

=====

PROVIDER: Nacogdoches Surgery Center  
THCIC ID: 723800  
QUARTER: 4  
YEAR: 2012

Certified With Comments

As is.

=====

PROVIDER: Outpatient Surgery Center  
THCIC ID: 794500  
QUARTER: 4  
YEAR: 2012

Certified With Comments

filed 4q late-in 03/2013

=====

PROVIDER: GAB Endoscopy Center  
THCIC ID: 799400  
QUARTER: 4  
YEAR: 2012

Certified With Comments

The 8 claims identified as duplicates are not duplicates

=====
PROVIDER: Medical Village Surgery Center
THCIC ID: 804300
QUARTER: 4
YEAR: 2012

Certified With Comments

There are two instances where the procedure date was entered in lieu of the patients date of birth, and two instances where the wrong charge was entered for a procedure.

=====
PROVIDER: Community Surgery Center
THCIC ID: 807500
QUARTER: 4
YEAR: 2012

Elected Not to Certify

Claims not reviewed by physicians.

=====
PROVIDER: Spinecare
THCIC ID: 816900
QUARTER: 4
YEAR: 2012

Elected Not to Certify

DATA GENERATED FROM SCHEDULING/BILLING SOFTWARE. WE CANNOT GUARANTEE 100% ACCURACY.

=====
PROVIDER: Memorial Hermann Surgery Center Woodlands
THCIC ID: 825400
QUARTER: 4
YEAR: 2012

Certified With Comments

No comments

=====
PROVIDER: Dallas Endoscopy Center
THCIC ID: 826200
QUARTER: 4
YEAR: 2012

Certified With Comments

I spot checked a few claims and it looks to be correct.

Outpatient Facility Comments, 4Q2012.txt

=====

PROVIDER: ADC Endoscopy Specialist  
THCIC ID: 837500  
QUARTER: 4  
YEAR: 2012

Certified With Comments

2 patients refused to give us their SSN.

=====

PROVIDER: Texas Health Outpatient Surgery Center Stephenville  
THCIC ID: 838800  
QUARTER: 4  
YEAR: 2012

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 outpatient claims for patients that receive outpatient surgical or radiological services, 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 outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes (CPT Codes). 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

Outpatient Facility Comments, 4Q2012.txt

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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

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.

=====

PROVIDER: Simmons Ambulatory Surgery Center  
THCIC ID: 843300  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a \$995 million enterprise that is licensed for 968 beds and employs approximately 9,474 staff. Approximately 1,584 patients received outpatient care in the clinics (both on campus and in the neighborhood-based

Outpatient Facility Comments, 4Q2012.txt  
health centers) this quarter.

Specific Data Concerns

As in other large academic medical centers, teams of physicians rotating at intervals care for patients. The THCIC dataset allows only one primary physician to be assigned to the patient for the entire inpatient stay. In our institution, this represents the physician caring for the patient at the time of discharge. Many patients, particularly long-term care patients are actually managed by as many as three to four different teams and attending physicians. For this reason, the practice of attributing patient outcomes to the report card of a single physician may result in misleading information.

=====

PROVIDER: Hyde Park Surgery Center  
THCIC ID: 867700  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Several patients refused to provide their social security number.

=====

PROVIDER: Abilene Surgery Center  
THCIC ID: 900002  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Certify without changes

=====

PROVIDER: Frisco Reproductive Surgery Center  
THCIC ID: 903000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Vendor correcting our submission added some third quarter data to the fourth quarter. See dates of service.

=====

PROVIDER: CHRISTUS Santa Rosa Physicians ASC New Braunfels  
THCIC ID: 917000  
QUARTER: 4  
YEAR: 2012

Certified With Comments

1677 events 2012 4th q completed

=====

PROVIDER: Seton Medical Center Hays  
THCIC ID: 921000  
QUARTER: 4

Outpatient Facility Comments, 4Q2012.txt

YEAR: 2012

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: 4
YEAR: 2012

Certified With Comments

The data reports for Quarter 4, 2012 do not accurately reflect patient volume or severity.

Patient Volume

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Severity

Not all clinically significant conditions, such as the hearts ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

=====
PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
QUARTER: 4
YEAR: 2012

Certified With Comments

Possible Duplicates because of DFWHC resubmission per THCIC

=====
PROVIDER: Methodist Willowbrook Hospital Outpatient Surgery Department
THCIC ID: 862300
QUARTER: 4
YEAR: 2012

Certified With Comments

1 record errored out incorrectly and failed to be submitted

=====
PROVIDER: Texas Health Heart & Vascular Hospital
Page 46

THCIC ID: 730001  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Data Content

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Diagnosis and Procedures

Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). 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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

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.

Outpatient Facility Comments, 4Q2012.txt

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.

=====
PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
QUARTER: 4
YEAR: 2012

Certified With Comments

The data reports for Quarter 4, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

=====
PROVIDER: JPS Surgical Center-Arlington
THCIC ID: 153300
QUARTER: 4

YEAR: 2012

Certified With Comments

Due to an Epic conversion Managed Medicare and Medicaid are classified as Commercial payers.

JPS Health Network  
Comments on THCIC Data Submission  
For  
4th Quarter 2012

Introduction

John Peter Smith Hospital (JPSH) is operated by the 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 was the first Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only 24-hour, seven-day a week psychiatric emergency center in the area. The hospital's special services include intensive care for adults and newborns, a special AIDS treatment center, a skilled nursing unit, a full-range of obstetrical and gynecological services, inpatient care for patients of all ages and an inpatient mental health treatment facility.

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

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

=====

PROVIDER: HMU Surgical Center  
THCIC ID: 194100  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Counts are to the best of our knowledge. KUB's performed on the same day were counted as a separate case due to billing software. Facility counts: October 322, November 327, December 282

=====

PROVIDER: Texas General Hospital  
THCIC ID: 115100  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Certify without comment.

Outpatient Facility Comments, 4Q2012.txt

=====

PROVIDER: Texas Health Harris Methodist Fort Worth Outpatient Surgery Center  
THCIC ID: 970100  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Data Content

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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 outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes (CPT Codes). 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-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

#### 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.

=====

PROVIDER: Dodson Surgery Center  
THCIC ID: 970400  
QUARTER: 4  
YEAR: 2012

#### Certified With Comments

Cook Children's Medical Center has submitted and certified 4th QUARTER 2012 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

4th QUARTER OF 2012.

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.

-----  
PROVIDER: Huguley Surgery Center  
THCIC ID: 971500  
QUARTER: 4  
YEAR: 2012

Elected Not to Certify

Due to the notification from THCIC, October 29, 2012 the THCIC Outpatient Technical Specification Manual was previously incorrect and specific revenue codes were unintentionally omitted from the manual, the Texas Health Huguley Surgery Center Outpatient dataset may have discharges included from a prior Certification quarter. THCIC merged the missing patient encounters back into the correct quarterly dataset. If the user of this dataset is able to filter the 4th quarter discharges from this dataset, the data should be accurate.

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of September 3, 2013. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC. 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

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not 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.

Outpatient Facility Comments, 4Q2012.txt

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using ICD-9-CM and CPT. 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-9-CM and CPT 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.

Given the current certification software, due to hospital volumes, it is not feasible to perform encounter level audits and edits. To meet the state's mandates to submit hospital Outpatient visits with specific procedures, Texas Health Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format.

All known errors have been corrected to the best of our knowledge. Due to the issues with discharges being merged between multiple quarters at THCIC, we chose not to certify the data for this quarter. However, the quarterly data to the best of our knowledge is accurate and complete given the above.

=====

PROVIDER: Baylor Medical Center McKinney  
THCIC ID: 971900  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to analyze the data. Regarding the mandate to communicate the Certification reports to physicians The State does not offer a secure mechanism for us to communicate other than the hard copy reports. At this time, we as a hospital are moving to limit or eliminate paper distribution and we do not have an internal system to communicate to all physicians feasibly.

Quality Trending of data over a few years is important to define outcome and quality. A small sampling of data (i.e. one year) does not explain outcome.

We recommend the Patient communicate with the Hospital and the Physician regarding data. Patient and physician preference contributes to the care rendered to the patient and the data does not always reflect this.

Patients and physicians consider many factors when making health care decisions that are not available in administrative data. These include a patient's preference for life-sustaining treatments, functional status, and other factors.

We support the Patient, Provider, and Payer and empowered, educated decision-making. Quality improvement is not new; it is an on-going commitment.

=====

PROVIDER: Pain Management Professionals of Baytown  
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Outpatient Facility Comments, 4Q2012.txt

THCIC ID: 972100  
QUARTER: 4  
YEAR: 2012

Certified With Comments

To my knowledge all claims entered are correct.

=====

PROVIDER: Texas Health Harris Methodist Hospital Alliance  
THCIC ID: 972900  
QUARTER: 4  
YEAR: 2012

Certified With Comments

Data Content

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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

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ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, 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.

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.