DSHS Publication #E25-12465

TEXAS Department of State Health Services
CHS-THCIC • 1100 W. 49th Street • M-660 • Austin Texas 78756 • Phone 512-458-7261 • www.dshs.state.tx.us/thcic

Hospital Numbered Letter Volume 9 Number1
January 9, 2006

Revised *Indicators of Inpatient Care in Texas Hospitals, 2003* to be Released

The annual *Indicators of Inpatient Care in Texas Hospitals*, a report on the performance by Texas hospitals on measures of quality in 2003 was released in September. After the release it was found that patients transferred to rehabilitation hospitals and some long-term care facilities were inadvertently excluded from the calculation. The mortality indicators, the only indicators affected by the omission, were re-calculated and hospitals completed their review of the revised indicators in December. The revised report will be released on the THCIC website on Monday, January 9.

Hospital Discharge Data Submission, Correction, and Certification Training Session

The next training session for submission, correction, and certification of THCIC data is scheduled for *Friday, March 10, 2006, from 9:00 am – 3:00 pm*.

The session will be held in Austin at the Department of State Health Services, 1100 W. 49th Street, Room K-100. If you plan to attend please contact Tiffany Overton at Tiffany.Overton@dshs.state.tx.us, 512-458-7111 x 2352, and provide the following information about yourself and your facility.

THCIC ID _____
Hospital/Organization _____
City _____
Registrant Name _____
Title _____
Phone Number _____
E-mail Address _____

You can attend one or all of them the training sessions. The PowerPoint presentations will be on the THCIC website http://www.dshs.state.tx.us/thcic/hospitals/HospitalReportingRequirements.shtm. Please print these presentations and bring them with you to the session. The tentative schedule follows:

9:00 Payer Source Data
9:15 Upload and Download of Data Using the Secured Server
10:15 Data Submission and KeyClaim Software
11:00 Data Correction, DCS Software
12:00 Lunch
1:00 Data Certification, CertView Software
2:15 Software Demonstrations

SB 872, 79th Texas Legislature

Senate Bill 872, 79th Texas Legislature (SB 872) affects "niche hospitals," physicians and DSHS, primarily. If you have questions, concerns or issues with this bill please contact your State Senator or State Representative.

A synopsis of the bill:

1. New language was added to Chapter 162.052 Occupations Code that requires a physician to notify the Department of State Health Services (DSHS) (*Division of Regulatory Services*) of any ownership interest held by the physician in a niche hospital.
2. New language was added to Chapter 96, Health and Safety Code. Occupations Code that a physician must notify patients in writing that there is an option of using an alternative health care facility, when the physician refers the patient to a "niche hospital" when the physician or a family member of the physician has an ownership interest in the "niche hospital". Otherwise it is considered unprofessional conduct.
3. DSHS must conduct a study to evaluate;
    a. the number of "niche hospitals" currently in operation
    b. the number of "niche hospitals" under construction or in planning phase of construction;
    c. the location of each "niche hospital";
    d. the financial impact of "niche hospitals" on general hospitals;
    e. the referral patterns of physicians with an ownership interest in "niche hospitals"; and
    f. the range of services "niche hospitals" provide;
4. New definitions were added to Chapter 96, Health and Safety Code and established "The Advisory Panel on Health Care Associated Infections"
5. **THCIC is required to produce a report using public use data that provides information for review and analysis by HHSC relating to:**
    a. services provided by "niche hospitals"; and
    b. **services that are provided by a physician with an ownership interest in the "niche hospital."**

SB 872 defines "Niche hospital"

(2) "Niche hospital" means a hospital that:

(A) classifies at least two-thirds of the hospital 's Medicare patients or, if data is available, all patients:

(i) in not more than two major diagnosis related groups; or

(ii) in surgical diagnosis-related groups;

(B) specializes in one or more of the following areas:

(i) cardiac;

(ii) orthopedics;

(iii) surgery; or

(iv) women 's health; and

(C) is not:

(i) a public hospital;

(ii) a hospital for which the majority of inpatient claims are for major diagnosis-related groups relating to rehabilitation, psychiatry, alcohol and drug treatment, or children or newborns; or

(iii) a hospital with fewer than 10 claims per bed per year.

House Bill 7, 79th Texas Legislature

House Bill 7, 79th Texas Legislature (HB 7) moved the Texas Workers Compensation Commission activities to the Texas Department of Insurance, Office of Injured Employee Counsel. **The bill did grant the authority to the Office of Injured Employee Counsel access to all data that THCIC collects** (Sec. 404.111. ACCESS TO INFORMATION). If you have questions, concerns or issues with this bill please contact your State Senator or State Representative.

2004 PUDF Release

Texas Health Care Information Collection (THCIC) announces the release of the 2004 Public Use Data File (PUDF) on December 22, 2005.

The data files for 2004 include 260 data fields in a base data file and 13 data fields in a detailed charges file. Data files for earlier years include only 105 data fields. Information on these additional data fields is included in the User Manual, available at <http://www.dshs.state.tx.us/THCIC/Hospitals/UserManual.pdf>. The files for 2004 include the following:

First quarter, 446 hospitals:	
Base data	715,238 records
Charges	11,224,522 records
Second quarter, 455 hospitals:	
Base data	696,199 records
Charges	10,941,539 records
Third quarter, 455 hospitals:	
Base data	703,413 records
Charges	10,942,371records
Fourth quarter, 453 hospitals:	
Base data	703,610 records
Charges	10,979,239 records

The PUDF contains data on hospital inpatient discharges and includes:

- Patient demographic data - including age group, sex, race and ethnicity
- Geographic data - including the patient's zip code
- Diagnoses and procedures
- Primary and secondary sources of payment - including detailed charges

The Texas PUDF is one of the largest sources of hospital discharge data in the U.S. It can be used for:

- Studying and improving health care services - including monitoring patient quality and outcomes
- Strategic planning - including comparative analyses and market assessment
- Marketing and business development - including program and product line planning

2005 PUDF

Pre-purchase the 2005 PUDF. Release dates are as follows:
1q05 – March 2006
2q05 – June 2006
3q05 – Sept 2006
4q05 – Dec 2006

Order form and Data User Agreement may be downloaded at:
http://www.dshs.state.tx.us/thcic/Hospitals/HospitalData.shtm.

Notification – Source of Payment Data Field

During a quality review of 1st quarter 2005 data, staff found that some payer name fields **contained names of individuals**, which may lead to **patient identification**. If the source for payment is an individual (e.g. patient or a relative to the patient), "**SELF PAY**" should be entered in the payer name field and "**SELF**" should be entered in the payer ID field. A person's name should not be used in either the primary or secondary payer name fields.

Important Phone Numbers

Commonwealth Clinical Systems (CCS)
THCIC Helpdesk – 888-308-4953 or THCICHelp@comclin.net
CCS web site – www.thcichelp.com (Please note that this is a new Web site for the THCIC help desk.)
HyperTerminal Phone Number – (434) 297-0367 (For Data Submission, Corrections and Uploading Certification Comments)
FTP address – ftp.comclin.com
THCIC web site – www.dshs.state.tx.us/thcic
DSHS-Center for Health Statistics – 512-458-7261
THCIC Staff – 512-458-7111

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Dee Roes	extension 3374	Hospital compliance, data sales
Tiffany Overton	extension 2352	Hospital training (submission, correction, and certification)
Ron Weiss	extension 6453	

THCIC fax – 512-458-7740

Reminders and Deadlines

The hospital discharge data schedule may be downloaded from
http://www.dshs.state.tx.us/THCIC/hospitals/schedule.shtm.

- 1/15/06 – **2q05** certification corrections must be submitted by this date
- 3/1/06 – **2q05** certification letter must be received by THCIC by this date
- 3/1/06 – Hospitals to retrieve the **3q05** certification file from mailbox at CCS
- 3/1/06 – **4q05** initial data submission, no later than date
- 3/10/06 – Hospital training in Austin

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Hospital Numbered Letter Volume 9 Number 2
March 9, 2006

Notification on Submissions – Data Contents

Payer Identification

There appears to be some misunderstanding as to the required contents of the Payer Identification data element in the NM1 Payer Name segment. This data element should contain the identifier of the payer. This is the identifier (plan ID) that the payer asked the hospital to use. This should not be the identification number of the patient or the responsible party as this could breach patient confidentiality. In the cases where the source of payment is Self Pay, Charity or Indigent, the values of "SELF", "CHARITY", and "INDIGENT" should be used. In the case of claims for which the payer is unknown, the value "UNKNOWN" should be used.

Payer Name

For claims where the source of payment is Self Pay, Charity, Indigent, or Unknown, the following terms should be used, respectively, in the Payer Name field. For Self Pay, use "SELF"; for Charity, use "CHARITY"; for Indigent, use "INDIGENT"; and for Unknown, use "UNKNOWN".

Practitioner License Number

Some claims contain practitioner license numbers that have a "TX" or "TXB" prefix. These prefixes were particular to the Medicaid program, but are not used in the THCIC data collection. Practitioner license numbers should not contain these prefixes as they may cause audit exceptions.

Payer Source Coding Guide Now Available

Review of 2004 data submissions has shown that there are different opinions as to assignment of the Payer Source Codes for the primary and secondary payers. This is understandable given that payers can sometimes be placed in more than one category. To assist with the code assignment, THCIC has developed a coding guide. This guide, while not mandatory, assists hospitals by providing a question test approach to the code assignment. A set of tests, in order of descending frequency, provides for code selection that results in consistent coding of payer sources. In most cases, the correct payer source can be identified within the first four tests.

In addition, THCIC has also developed definitions for the payer codes that are consistent with the coding guide. The Payer Source Code Guide and Definitions are included at the end of this Numbered Letter.

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HyperTerminal Phone Number – (434) 297-0367 (For Data Submission, Corrections and Uploading Certification Comments)

Secured Web Page – https://sys1.comclin.com/thcic/

THCIC web site – www.dshs.state.tx.us/thcic

DSHS-Center for Health Statistics – 512-458-7261

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Reminders and Deadlines

The hospital discharge data schedule may be downloaded from http://www.dshs.state.tx.us/THCIC/hospitals/schedule.shtm.

- 3/10/06 – Hospital training in Austin
- 4/15/06 - Cutoff for 3q05 certification corrections
- 5/1/06 – Cutoff for 4q05 corrections

Payer Source Coding Guide

IF	Then Use	Code
Medicaid (including HMO, PPO, EPO, POS) or CHIP/SCHIP		MC
Medicare Health Maintenance Organization (HMO)		16
Medicare Part B or Medicare Outpatient		MB
Medicare Part A or Medicare (including PPO, EPO, POS, Indemnity)		MA
Preferred Provider Organization (PPO)		12
Health Maintenance Organization (HMO)		HM
Local or State Program (including county or hospital district indigent/charity)		OF
Self/Private Pay		09
Unknown		ZZ
Hospital charity		ZZ
CHAMPUS		CH
Veterans Administration Plan		VA
Exclusive Provider Organization (EPO)		14
Point of Service (POS)		13
Automobile Medical or No-Fault Insurance		AM
Liability		LI
Liability Medical		LM
Disability		DS
Title V or Children with Special Health Care Needs (CSHCN) Services Program		TV
Veterans Administration Plan		VA
If none of the above, will be Indemnity		15

CATEGORY DESCRIPTIONS

09 Self pay
Payment responsibility is borne by the patient or another individual and not by a federal, state, local or private organization.

If payment is made by the patient or an individual, use "SELF PAY" in Payer Organization Name field and use ""SELF" in Payer Identification field.

10 Central certification
Definition is unknown. Category is not used.

11 Other non-federal program
Payment is made by a state or local program and most likely funded by tax dollars. This could include claims for which application to a program has been made but eligibility has not been determined.

12 Preferred Provider Organization (PPO)
PPO is a type of managed care insurance. PPO plans combine some elements of the HMO plan with elements of the indemnity plan. Like HMOs, the PPO plans have contracts with a specific list of medical providers. The enrollees may go outside of the network, but will incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

13 Point of Service (POS)
POS is a type of managed care and the category is new with the THCIC 837. A POS is an HMO/PPO hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans.

14 Exclusive Provider Organization (EPO)
EPO is a type of managed care and the category is new with the THCIC 837. An EPO is a more restrictive type of preferred provider organization plan under which beneficiaries must use providers from a specific network of physicians and hospitals to receive coverage. In most cases, there is no coverage for care received from a non-network provider except in an emergency situation.

15 Indemnity Insurance
This is the traditional insurance coverage most individuals have. Also known as traditional or fee-for-service plans, indemnity plans, whether group or individual. An indemnity plan reimburses the patient and/or provider as expenses are incurred. Indemnity plans usually do not require beneficiaries to choose from a provider network for covered care. Unless specified otherwise as PPO, HMO, EPO, an individual or group plan is an indemnity plan.

16 Health Maintenance Organization – Medicare Risk
Medicare risk is a contractual relationship between CMS and HMO managed care plans where the plan provides specific health care benefits to beneficiaries in exchange for a prepaid fixed monthly amount from CMS. These benefits replace traditional Medicare benefits. Programs

included in the Medicare managed care risk programs fall under the Medicare + Choice contract. These are called Coordinated Care Plans.

AM Automobile Medical
This category is new with the THCIC 837. Automobile medical or no-fault insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile.

BL Blue Cross
This category refers to a specific insurance company. Blue Cross provides many different plan options (PPO, HMO).

THCIC recommends that this category not be used.

CH CHAMPUS
CHAMPUS is a health benefits program offered through the Military Health Services System of the Department of Defense of inactive military, their spouses, dependents and beneficiaries. CHAMPUS provides authorized in-patient and out-patient care from civilian sources, on a cost-sharing basis. Retired military are eligible, as well as dependents of active-duty, retired and deceased military. Also known as TRICARE.

CHAMPUS: *Civilian Health and Medical Program of the Uniformed Services*

CI Commercial Insurance
This category is misinterpreted as being any insurance that can be purchased on the open market (commercially). However, there are other categories that provide more specific categorization.

THCIC recommends that this category not be used.

DS Disability
Disability insurance pays benefits in the event that the policy holder becomes incapable of working. This does not include workers compensation insurance.

Types of disability insurance include:
- Short-term disability: a disability not lasting longer than six months.
- Partial disability: Any condition, resulting from illness or injury, that keeps an insured from performing one or more occupation related activities.
- Total disability: A disability that prevents an insured from performing duties essential to his/her regular job.
- Permanent disability: An inability to work at any job.

HM Health Maintenance Organization (HMO)
An HMO is an organized system that arranges or provides a set of health care services to members in return for a prepaid or periodic charge paid by or on the behalf of the enrollees.

Membership in an HMO requires plan members to obtain their health services from doctors and hospitals affiliated with the HMO. Members usually select a primary care physician who manages all of the health care and serves as a gatekeeper for specialty care.

LI Liability
Insurance which pays and renders service on behalf of an insured for loss arising out of his/her responsibility to others imposed by law or assumed by contract.

Types of liability insurance include homeowner's insurance, umbrella liability insurance for individuals and companies.

LM Liability Medical
Insurance which pays only for medical services on behalf of an insured for loss arising out of the insured's responsibility to others imposed by law or assumed by contract.

MA Medicare Part A
Federal insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part A covers in-hospital services.

MB Medicare Part B
Federal insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part B covers physician and other outpatient services.

MC Medicaid
Medicaid is a jointly funded, federal – state, health insurance program for low-income and needy people. Medicaid is run by the state and covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. The state provides Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. This includes the CHIP/SCHIP programs.

TV Title V
The Children with Special Health Care Needs (CSHCN) Services Program, funded through the Title V Block grant, provides services to children with extraordinary medical needs, disabilities, and chronic health conditions. The CSHCN Services Program's health care benefits include payments for medical care, family support services, and related services not covered by Medicaid, CHIP, private insurance, or other third party payors.

OF Other Federal Program
Programs, other than Medicare, Medicaid, CHAMPUS and Veteran's Administration, that pay for health services through tax-funded programs. Such programs include Indian Health Service, Federal incarceration, US Marshall's Office, and Crime Victims.

VA Veterans Administration Plan
The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to its customers. Services are provided primarily in VHA facilities.

WC Workers Compensation Health Plan
Workers Compensation insurance covers the cost of medical care and rehabilitation for workers injured on the job. It also compensates them for lost wages and provides death benefits for their dependents if the workers are killed in work-related accidents, including terrorist attacks.

ZZ Charity or Unknown
This category is new with the THCIC 837. This category is used to report services that will not be paid for or reimbursed by a local, county, or state program or by private insurance. It is also used to report claims for which the payer source is unknown at the time that the claim is reported to THCIC.

If no payment is expected, enter "CHARITY" in Payer Organization Name and in Payer Identification fields.

If the payer is unknown at the time the claim is reported to THCIC, enter "UNKNOWN" in Payer Organization Name and in Payer Identification fields.

If an application has been made to Medicaid or another state or local program, "*Program name* Application" may be used in Payer Organization Name field.

DSHS Publication #E25-12465

March 30, 2006 Vol 9 Num 3

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Hospital Numbered Letter Volume 9 Number 3

March 30, 2006

Revision to Numbered Letter Volume 9 Number 2

Payer Source Coding Guide has been revised. See below.

1Q05 PUDF

The 1Q05 PUDF will be released on April 6, 2006. Pre-purchasers of the 1Q05 PUDF should receive their copy by April 10th.

Importance of Physician IDs

THCIC assigns uniform identifiers to the Attending and Operating Physicians associated with each patient discharged. These uniform identifiers are required by law and are assigned to protect physicians' identities. (*There are civil and criminal penalties [§§108.014 and 108.0141, Health and Safety Code, respectively] that can be assessed if someone uses the THCIC data to identify physicians.*) By using the uniform physician identifiers, a hospital or other data user is able to track a physician across hospitals and across quarters to determine outcome variations and practice patterns without being able to identify the physician. The identifier can also be used to determine the number of physicians using a particular procedure, both in a hospital or a geographic area.

The uniform physician identifier '9999999999' is assigned if the physician has a temporary license or if the physician information provided to THCIC is not correct and cannot be matched with THCIC's physician files. While some '9999999999' identifiers are unavoidable, valid research cannot be done if a hospital has a large percentage of '9999999999' identifiers because of the quality of the data submitted to THCIC. This can also result in concerns about the accuracy of other data submitted to THCIC by the hospital. Facilities that choose not to correct the physician name and identification numbers are technically in violation of the Hospital Discharge Data rules 25 TAC §421.7 (g) under Certification of Discharge Reports.

Hospital Encounter/Certification Files

Hospitals are provided 90 days to download and review their encounter files, and submit a certification letter to THCIC for each data quarter. The THCIC helpdesk sends notification to each hospital when the encounter files are ready for download from the hospital's electronic mailbox at CCS. Notifications are sent frequently until the files are downloaded by the hospital. Once the deadline for submitting the certification letter passes, CCS **removes** that "quarter" encounter file from the mailbox if it has not been downloaded by the hospital. CCS will charge hospitals to reload the encounter file into the hospitals mailbox if the hospital chooses to download the encounter file after the deadline for submitting that quarter's certification letter.

Certification Letters

Hospitals must print out the quarterly certification letter using the CertView Software after importing the encounter/certification file into this program. Beginning with the 1q06 certification process, THCIC will no longer accept the "generic" certification letter or "white-out" copies.

Instructions for "Certification" are on the THCIC web site at http://www.dshs.state.tx.us/THCIC/Hospitals/CertManual.doc.

If the "pre-printed" certification letter has incorrect contact information, the hospital should update THCIC with the correct information prior to submitting the certification letter. Hospitals should use the form located at http://www.dshs.state.tx.us/THCIC/hospitals/HospitalInformationRequest.doc for submitting updates.

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Reminders and Deadlines

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- 4/15/06 - Cutoff for 3q05 certification corrections
- 5/1/06 – Cutoff for 4q05 corrections

Payer Source Coding Guide (Updated)

Descending order of frequency

IF	Then Use	Code
Medicaid (including HMO, PPO, EPO, POS) or CHIP/SCHIP		MC
Medicare Health Maintenance Organization (HMO)		16
Medicare Part B or Medicare Outpatient		MB
Medicare Part A or Medicare (including PPO, EPO, POS, Indemnity)		MA
Preferred Provider Organization (PPO)		12
Health Maintenance Organization (HMO)		HM
Local or State Program (including county or hospital district indigent program)		11
Self/Private Pay		09
Unknown		ZZ
Hospital charity		ZZ
CHAMPUS		CH
Veterans Administration Plan		VA
Exclusive Provider Organization (EPO)		14
Point of Service (POS)		13
Automobile Medical or No-Fault Insurance		AM
Liability		LI
Liability Medical		LM
Disability		DS
Other Federal Programs not listed above (including Indian Health Service, Federal incarceration, Crime victims, US Marshall's office)		OF
Workers Compensation Health Plan		WC
Title V Children with Special Health Care Needs (CSHCN) Services Program		TV
If none of the above, will be Indemnity		15

09 Self pay
Payment responsibility is borne by the patient or another individual and not by a federal, state, local or private organization. Includes Medical or Health Savings Accounts.

If payment is made by the patient or an individual, use "SELF PAY" in Payer Organization Name field and use ""SELF" in Payer Identification field.

10 Central certification
Definition is unknown. Category is not used.

11 Other non-federal program
Payment is made by a state or local program and most likely funded by tax dollars. This could include claims for which application to a program has been made but eligibility has not been determined. Can include entities such as the Texas Rehabilitation Commission, Texas Kidney Foundation, non-federal incarceration and adoption agencies.

12 Preferred Provider Organization (PPO)

PPO is a type of managed care insurance. PPO plans combine some elements of the HMO plan with elements of the indemnity plan. Like HMOs, the PPO plans have contracts with a specific list of medical providers. The enrollees may go outside of the network, but will incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

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15 Indemnity Insurance
This is a fee-for-service health insurance plan that is not otherwise specified as a PPO, HMO, or EPO, whether group or individual. It includes individual insurance and an employer's self-funded insurance. An indemnity plan reimburses the patient and/or provider as expenses are incurred. Indemnity plans usually do not require beneficiaries to choose from a provider network for covered care.

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This category refers to a specific insurance company. Blue Cross provides many different plan options (PPO, HMO).

THCIC recommends that this category not be used.

CH CHAMPUS
CHAMPUS is a health benefits program offered through the Military Health Services System of the Department of Defense of inactive military, their spouses, dependents and beneficiaries. CHAMPUS provides authorized in-patient and out-patient care from civilian sources, on a cost-sharing basis. Retired military are eligible, as well as dependents of active-duty, retired and deceased military. Also known as TRICARE.

CHAMPUS: *Civilian Health and Medical Program of the Uniformed Services*

CI Commercial Insurance
This category is misinterpreted as being any insurance that can be purchased on the open market (commercially). However, there are other categories that provide more specific categorization.

THCIC recommends that this category not be used.

DS Disability
Disability insurance pays benefits in the event that the policy holder becomes incapable of working. This does not include workers compensation insurance or other tax-funded programs.

Types of disability insurance include:
- Short-term disability: a disability not lasting longer than six months.
- Partial disability: Any condition, resulting from illness or injury, that keeps an insured from performing one or more occupation related activities.
- Total disability: A disability that prevents an insured from performing duties essential to his/her regular job.
- Permanent disability: An inability to work at any job.

HM Health Maintenance Organization (HMO)
An HMO is an organized system that arranges or provides a set of health care services to members in return for a prepaid or periodic charge paid by or on the behalf of the enrollees.

Membership in an HMO requires plan members to obtain their health services from doctors and hospitals affiliated with the HMO. Members usually select a primary care physician who manages all of the health care and serves as a gatekeeper for specialty care.

LI Liability
Insurance which pays and renders service on behalf of an insured for loss arising out of his/her responsibility to others imposed by law or assumed by contract.

Types of liability insurance include homeowner's insurance, umbrella liability insurance for individuals and companies.

LM Liability Medical
Insurance which pays only for medical services on behalf of an insured for loss arising out of the insured's responsibility to others imposed by law or assumed by contract.

MA Medicare Part A
Federal insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part A covers in-hospital services.

MB Medicare Part B
Federal insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part B covers physician and other outpatient services.

MC Medicaid
Medicaid is a jointly funded, federal – state, health insurance program for low-income and needy people. Medicaid is run by the state and covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. The state provides Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. This includes the CHIP/SCHIP programs.

OF Other Federal Program
Federal tax-funded programs, other than Medicare, Medicaid, CHAMPUS and Veteran's Administration, that pay for health services. Such programs include Indian Health Service, Federal incarceration, US Marshall's Office, and Crime Victims.

TV Title V
The Children with Special Health Care Needs (CSHCN) Services Program, funded through the Title V Block grant, provides services to children with extraordinary medical needs, disabilities, and chronic health conditions. The CSHCN Services Program's health care benefits include payments for medical care, family support services, and related services not covered by Medicaid, CHIP, private insurance, or other third party payors.

VA Veterans Administration Plan
The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to its customers. Services are provided primarily in VHA facilities.

WC Workers Compensation Health Plan
Workers Compensation insurance covers the cost of medical care and rehabilitation for workers injured on the job. It also compensates them for lost wages and provides death benefits for their dependents if the workers are killed in work-related accidents, including terrorist attacks.

ZZ Charity or Unknown

This category is new with the THCIC 837. This category is used to report services that will not be paid for or reimbursed by a local, county, or state program or by private insurance. It is also used to report claims for which the payer source is unknown at the time that the claim is reported to THCIC.

If no payment is expected, enter "CHARITY" in Payer Organization Name and in Payer Identification fields.

If the payer is unknown at the time the claim is reported to THCIC, enter "UNKNOWN" in Payer Organization Name and in Payer Identification fields.

If an application has been made to Medicaid or another state or local program, "*Program name* Application" may be used in Payer Organization Name field.

DSHS Publication #E25-12465

May 31, 2006 Vol 9 Num 4

TEXAS Department of State Health Services

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Hospital Numbered Letter Volume 9 Number 4

May 31, 2006

New Version of CertView

A new version of CertView is now available for hospitals to download. This version must be used to certify the data for **fourth quarter 2005** now available to hospitals.

The new CertView includes a report, "Duplicated Encounters Summary Report," of possible duplicate encounters found in the data. The new report can be accessed from the Reports/Processing Results dropdown option. The report includes two types of possible duplicates:

1. Encounters with the same Statement From and Thru dates, but with slightly different Medical Record Numbers or Patient Control Numbers.
2. Encounters with the same Medical Record Numbers and Patient Control Numbers, but with Statement From and Thru dates of one encounter that cross over the dates of another encounter.

The records are displayed as pairs that appear to be related. One pair may include encounter A and B, the second pair may include encounter B and C, and they may all be related to the same hospital stay. Examination of the pairs will show the key data elements—Medical Record Number, Patient Control Number, Statement From or Thru dates—that are slightly different. The Medical Record Number, Patient Control Number, and dates of service are required to be the same in order to link the claims into a single encounter.

The report will have data only for those hospitals where possible duplicate encounters were found, otherwise the report will state "NO DUPLICATE or CROSS-OVER ENCOUNTERS DETECTED". Those hospitals that have a report of possible duplicate encounters may correct the data that caused the claims to not be correctly combined in an encounter. The encounters can then be regenerated for a fee.

Duplicate encounters in a hospital's data can result in a hospital's encounter volume being overstated and will affect any reporting on the hospital.

THCIC Welcomes Bryan Shepherd

Bryan Shepherd joined the THCIC staff on May 8. He came to THCIC from the University of Texas at Austin Division of Instructional Innovation and Assessment. He expects to complete the requirements for his doctorate in sociology in 2007.

Bryan is working on *Indicators of Inpatient Care in Texas Hospitals* for 2004 and will make that available for hospital review soon. He will be available to answer your questions about the report when it is available for review.

Hospital Discharge Data Training Session

The next training session for submission, correction, and certification of THCIC data is scheduled for *Friday, July 14, 2006, from 9:00 am – 2:00 pm*.

The session will be held in Austin at the Department of State Health Services, 1100 W. 49th Street, Room K-100. If you plan to attend please contact Tiffany Overton at Tiffany.Overton@dshs.state.tx.us, 512-458-7111 x 2352, and provide the following information about yourself and your facility.

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You can attend one or all of them the training sessions. The PowerPoint presentations will be on the THCIC website http://www.dshs.state.tx.us/thcic/hospitals/HospitalReportingRequirements.shtm. Please print these presentations and bring them with you to the session. The tentative schedule follows:

9:00 Payer Source Data
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THCIC Staff – 512-458-7111

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Dee Roes	extension 3374	Hospital compliance, data sales
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THCIC fax – 512-458-7740

Reminders and Deadlines

The hospital discharge data **schedule** may be downloaded from http://www.dshs.state.tx.us/THCIC/hospitals/schedule.shtm.

- 6/1/2006 – 1q2006 inpatient discharge data due to THCIC
- 6/1/2006 – Hospitals to retrieve the 4q2005 certification/encounter file from CCS
- 6/1/2006 – 3q2005 certification letter due to THCIC

DSHS Publication #E25-12465

June 9, 2006 Vol 9 Num 5

TEXAS Department of State Health Services

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Hospital Numbered Letter Volume 9 Number 5

June 9, 2006

Indicators of Inpatient Care in Texas Hospitals, 2004

THCIC will release the *2004 Indicators of Inpatient Care* report in August 2006. Hospitals will be given the opportunity to review and comment on the report prior to its release. THCIC has mailed letters to the THCIC hospital primary contact on June 6th, providing each reporting hospital with information allowing access to a restricted website for viewing the data in the report. Only hospitals that reported 2004 data to THCIC will receive access. This site will be available for review beginning June 15, 2006 and ending August 13, 2006. Questions regarding access may be directed to Bryan Shepherd at 512-458-7111 ext 6453.

Changes in *Indicators of Inpatient Care in Texas Hospitals* for 2004

The data used to create the report for 2004 included variables derived from Version 20 of the 3M APR-DRG Grouper. These variables are used in the risk adjustment of the mortality indicators and some utilization indicators. Version 15 of the APR-DRG Grouper was used for grouping the data used for earlier reports.

Two indicators, Pediatric Heart Surgery Volume and Pediatric Heart Surgery Mortality, have been dropped from the report for 2004. These indicators are part of a new set of indicators, Pediatric Quality Indicators, specific to children currently being reviewed by THCIC. Pediatric populations, patients under age 18, have also been excluded from the following 13 indicators:

- Esophageal Resection Volume and Mortality
- Pancreatic Resection Volume and Mortality
- Abdominal Aortic Aneurysm (AAA) Repair Volume and Mortality
- Carotid Endarterectomy Volume and Mortality
- Coronary Artery Bypass Graft Volume
- Percutaneous Transluminal Coronary Angioplasty (PTCA) Volume
- Hip Replacement Mortality
- Laparoscopic Cholecystectomy
- Bilateral Cardiac Catheterization

Procedure codes have been added to the Esophageal Resection and AAA Repair indicators. A procedure code was dropped from the PTCA indicators. Diagnosis codes were dropped from the inclusion criteria for Esophageal Resection and Pancreatic Resection volume indicators. Because of these changes volumes and rates for 2004 should not be compared with those for earlier years.

New Pediatric Quality Indicators

Pediatric Quality Indicators (PedQIs), indicators specific to children, have been released by the Agency for Healthcare Research and Quality (AHRQ). The indicators have been drawn from AHRQ's Inpatient Quality Indicators (IQIs), Patient Safety Indicators (PSIs), and Prevention Quality Indicators (PQIs). They focus on potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals, and on preventable hospitalizations among pediatric patients. The indicators were initially released in February 2006, with the risk-adjustment module released in May.

The indicators included in the PedQIs are:

Provider-level Pediatric Quality Indicators (13 Indicators)

- Accidental Puncture or Laceration
- Decubitus Ulcer
- Foreign Body Left During Procedure
- Iatrogenic Pneumothorax in Neonates at Risk
- Iatrogenic Pneumothorax in Non-neonates
- Pediatric Heart Surgery Mortality
- Pediatric Heart Surgery Volume
- Postoperative Hemorrhage or Hematoma
- Postoperative Respiratory Failure
- Postoperative Sepsis Wound Dehiscence
- Postoperative Wound Dehiscence
- Selected Infections Due to Medical Care
- Transfusion Reaction

Area-level Pediatric Quality Indicators (5 Indicators)

- Asthma Admission Rate
- Diabetes Short-Term Complication Rate
- Gastroenteritis Admission Rate
- Perforated Appendix Admission Rate
- Urinary Tract Infection Admission Rate

The children's hospitals have been reviewing the indicators since November 2005. The National Association of Children's Hospitals and Related Institutions (NACHRI) and Child Health Corporation of America (CHCA) have been instrumental in this review. NACHRI earlier worked with some children's hospitals in a validation of the PSIs. This validation used a secure, web-based chart review tool developed by NACHRI that allowed the hospitals to review individual charts to determine whether a patient was appropriately included in an indicator. This chart review tool is also being used to validate the PedQIs. Using data submitted to NACHRI or CHCA, each participating hospital will receive a list of patients included in one of the indicators. Hospitals will use this list to pull patient charts, sampling a minimum of 10 cases for each of the PedQIs. The review is expected to begin in mid-June and to be completed by the end of July. The results of this review will be provided to AHRQ to help refine the current PedQIs and potentially guide the creation of new indicators in the future.

Participation in the PedQI review is open to any hospital supplying data to NACHRI or CHCA. Eight Texas children's hospitals are participating in the review of the PedQIs. 20 non-Texas hospitals have already responded to NACHRI that they would also like to participate in the review or would like additional information.

Release of 2Q2005 Public Use Data File (PUDF)

THCIC will release the 2q2005 PUDF on June 23rd. Those wishing to purchase the PUDF may download the order form and "data user agreement" at http://www.dshs.state.tx.us/thcic/Hospitals/HospitalData.shtm.

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Reminders and Deadlines

The hospital discharge data **schedule** may be downloaded from http://www.dshs.state.tx.us/THCIC/hospitals/schedule.shtm.

- 6/23/2006 – Release of the 2q2005 PUDF
- 7/14/2006 – Hospital Training in Austin

DSHS Publication #E25-12465
September 29, 2006 Vol 9 Num 6

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Hospital Numbered Letter Volume 9 Number 6
September 29, 2006

Indicators of Inpatient Care in Texas Hospitals, 2004 to be Released

THCIC will release the annual report on Texas hospitals on October 3, 2006. The report is based on methodology developed by the Agency for Healthcare Research and Quality (AHRQ). The indicators include three distinct types of measures:

Volume indicators look at the number of inpatient procedures performed at a hospital. The procedures measured are those for which a link between the number of procedures performed and the outcome has been demonstrated.
Mortality indicators present risk-adjusted mortality rates for select medical procedures and conditions.
Utilization indicators provide risk-adjusted rates for the use of certain procedures about which questions have been raised about appropriate use.

The hospital performance report and searchable database based on 2004 will be available on the DSHS/THCIC website on October 3.

Release of Third Quarter 2005 Public Use Data File (PUDF)

THCIC will ship the Third Quarter 2005 PUDF early next week to those who have purchased the data. Those wishing to purchase the PUDF may download the order form and "Data Use Agreement" at http://www.dshs.state.tx.us/thcic/Hospitals/HospitalData.shtm.

Certification Letters

Hospitals must print out the quarterly certification letter using the CertView Software after importing the encounter/certification file into this program. Beginning with the 1q06 certification process, THCIC will no longer accept the "generic" certification letter or "white-out" copies.

Instructions for "Certification" are on the THCIC web site at http://www.dshs.state.tx.us/THCIC/Hospitals/CertManual.doc.

If the "pre-printed" certification letter has incorrect contact information, the hospital should update THCIC with the correct information prior to submitting the certification letter. Hospitals should use the form located at http://www.dshs.state.tx.us/THCIC/hospitals/HospitalInformationRequest.doc for submitting updates.

Certview Software Update

An update to CertView, Version 2.3, corrects a problem that was found in the C01 Certification Summary Report. The error caused the report to show all state values not equal to 'FC' or blank as valid in-state codes. With the correction, the valid codes 'FC' and 'XX' are now correctly interpreted. Valid codes for Canadian provinces are correctly interpreted as out-of-country codes. The report now displays the total number of blanks and all other invalid codes in the field.

The information below will be posted on the THCICHelp downloads website http://www.thcichelp.com/Support.htm#Downloads when the update is released September __. The update can be downloaded and installed in one of two ways:

1. Full Installation:
   A complete installation that requires you to uninstall any earlier version of CertView. Do not delete the folder C:\Program Files\Certview\).

2. Executable Only:
   For users who already have CertView version 2.2 installed. This does not require you to uninstall and reinstall CertView.
   Download the file to the CertView directory. The pathname will be:
   C:\Program Files\CertView\CertView.exe.

Increase in Commonwealth's Charges for Services

Commonwealth's charges for services increased by 3%, effective September 1. The new rates are:

Hourly programming charge--$87.55
Rate for corrections during certification--$87.55
Rate for recreating certification files--$342

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- 11/1/2006 – Cutoff for 2q06 corrections
- 12/1/2006 - 1q06 Certification Letters due
- 12/1/2006 – 3q06 data submission due
- 12/1/2006 – Hospitals to begin review of 2q06 certification files