Outpatient Facility Comments, 1Q2010

General Comments on 1st Quarter 2010 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: Matagorda Regional Medical Center
THICIC ID: 006000
QUARTER: 1
YEAR: 2010

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
THICIC ID: 020000
QUARTER: 1
YEAR: 2010

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: 1
YEAR: 2010

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.

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PROVIDER: Baylor Medical Center at Carrollton
THCIC ID: 042000
QUARTER: 1
YEAR: 2010

Certified With Comments

DATA Content
This data is administrative data, which hospitals collect for billing purposes, and not clinical data in medical records, from which you can make judgements about patient care.

The state requires us to submit claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format.

Submission Timing
The hospital estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. 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 states 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 states data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of the patients hospitalization, sometimes significantly.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patients 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 system 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.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes in an individual patients record may have been assigned. This means also that true total volumes may not be represented by the states data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Specialty Services
The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehabilitation) provided to a patient. Services used by patients in rehabilitation may be very different from those used in other specialties. The data is limited in its ability to categorize patient type.
Services utilized by patients n specialty units may be very different from those used in acute care. Conditions such as stroke and hip replacement typically require a lower level of care, a longer length of stay, and a different utilization of service.

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 as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does have an inpatient rehabilitation unit whose patients stay an average of 12 days. This may skew the data when combined with other acute care patient stays.

Normal Newborns
The best way to focus on severity of illness regarding an infant would be to check the infants diagnosis at discharge, not the admitting source code. The hospitals normal hospital registration process defaults normal delivery as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Race/Ethnicity

During the hospitals registration process, the registration clerk does routinely complete patients race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patients race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the states race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Cost/Revenue
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. Charges also do not reflect the actual costs to deliver the care that each patient needs.

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.
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PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
QUARTER: 1
YEAR: 2010

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of December 1, 2010. 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.

Physician
While the hospital documents many treating physicians for each case, the THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians. Many physicians provide care to patients throughout a hospital stay. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Analysis of "Other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, 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. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Hunt Regional Medical Center Greenville
THCIC ID: 085000
QUARTER: 1
YEAR: 2010

Certified With Comments

4th Qtr included with 1st Qtr certification

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PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
QUARTER: 1
YEAR: 2010

Certified With Comments

The data reports for Quarter 1, 2010 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 registrations and billing data.

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PROVIDER: Memorial Hermann Southeast Hospital
THCIC ID: 119000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: University Medical Center
THCIC ID: 145000
QUARTER: 1
YEAR: 2010

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: TIRR Memorial Hermann
THCIC ID: 164000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.

2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: Memorial Hermann Northwest Hospital
THCIC ID: 172000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 1
YEAR: 2010

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
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: Houston Northwest Medical Center
THCIC ID: 229000
QUARTER: 1
YEAR: 2010

Certified With Comments

We certify with out comments.

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
QUARTER: 1
YEAR: 2010

Certified With Comments

Data Content
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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.

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PROVIDER: North Bay Hospital
THCIC ID: 239001
QUARTER: 1
YEAR: 2010

Certified With Comments

Computer glitches resulted in outdated HCPCS codes to be submitted for certain procedures or none to be submitted.
Also, dates for procedures were not submitted. Generally, the date is the same as those spanning only 1 day of service.

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PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
QUARTER: 1
YEAR: 2010

Certified With Comments

Data Content
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PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Wilson N Jones Medical Center
THCIC ID: 297000
QUARTER: 1
YEAR: 2010

Certified With Comments

Data is submitted to DFWHC correctly. THCIC isnt taking into consideration the way hospitals bill outpatient data. All payors are allowing the billing of claims to be submitted this way without a claim(s) rejecting. The edit that THCIC has implemented isnt working correctly. Also, the THCIC reference tables need to be updated with correct versions.

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PROVIDER: North Texas Medical Center
THCIC ID: 298000
QUARTER: 1
YEAR: 2010

Elected Not to Certify

The data for the first quarter of 2010 was not corrected.

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PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
QUARTER: 1
YEAR: 2010

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: Memorial Hermann Memorial City Medical Center
THCIC ID: 302000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 1
YEAR: 2010

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
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: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
QUARTER: 1
YEAR: 2010

Certified With Comments

Data Content
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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.

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PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 1
YEAR: 2010

Certified With Comments

Cook Children's Medical Center has submitted and certified 1st QUARTER 2010 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 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 1st QUARTER OF 2010.

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: University Medical Center-Brackenridge
THCIC ID: 335000
QUARTER: 1
YEAR: 2010

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.

Thanks,

Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals

512-324-1000 x10245

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PROVIDER: Memorial Hermann Hospital
THCIC ID: 347000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Baylor Medical Center-Southwest Fort Worth
THCIC ID: 363001
QUARTER: 1

YEAR: 2010

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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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.

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PROVIDER: Medical Center-Lewisville
THCIC ID: 394000
QUARTER: 1
YEAR: 2010

Certified With Comments

When reviewing the data for the Medical Center of Lewisville, please consider the following:

The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

The cost of care, charges, and the revenue a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to another may result in unreliable results.

Admission source data is not collected and grouped at the Medical Center of Lewisville in the same manner as displayed.

Under the Standard Source of Payment, please note that statistics in the "Commercial" category also includes managed care providers.

The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. The Medical Center of Lewisville is unable to comment on the accuracy of this report.

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PROVIDER: Memorial Hermann Southwest Hospital
THCIC ID: 407000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

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2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 1
YEAR: 2010

Certified With Comments

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 II 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.

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 1
YEAR: 2010

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.

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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.

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 1
YEAR: 2010

Certified With Comments

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PROVIDER: Texas Health Presbyterian Hospital-Winnsboro
THCIC ID: 446000
QUARTER: 1
YEAR: 2010

Certified With Comments

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

Cost/ Revenue Codes
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: DeTar Hospital-Navarro
THCIC ID: 453000
QUARTER: 1
YEAR: 2010

Certified With Comments

The DeTar Healthcare System includes two full-service 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. 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; Certified Chest Pain Center; Inpatient and Outpatient Rehabilitation Centers; DeTar SeniorCare Center; Senior Circle; Community Mother & Child Health Center; Primary Stroke Center; and a free Physician Referral Call Center. To learn more, please visit our website at www.detar.com.

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PROVIDER: DeTar Hospital-North
THCIC ID: 453001
QUARTER: 1
YEAR: 2010

Certified With Comments

The DeTar Healthcare System includes two full-service 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. 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; Certified Chest Pain Center; Inpatient and Outpatient Rehabilitation Centers; DeTar SeniorCare Center; Senior Circle; Community Mother & Child Health Center; Primary Stroke Center; and a free Physician Referral Call Center. To learn more, please visit our website at www.detar.com.

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PROVIDER: Val Verde Regional Medical Center
THCIC ID: 462000
QUARTER: 1
YEAR: 2010

Certified With Comments

without comments

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PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
QUARTER: 1
YEAR: 2010

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
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: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 1
YEAR: 2010

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 8,401 staff. Approximately 66,626 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: Seton Medical Center
THCIC ID: 497000
QUARTER: 1
YEAR: 2010

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.

Thanks,

Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals
512-324-1000 x10245

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PROVIDER: Baylor Regional Medical Center-Grapevine
THCIC ID: 513000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Memorial Hermann Katy Hospital
THCIC ID: 534001
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

PROVIDER: Methodist Richardson Medical Center
THCIC ID: 549000
QUARTER: 1
YEAR: 2010

Certified With Comments

Ken Approved on 11-24-10 everything looks good. TPM

PROVIDER: Bush Renner
THCIC ID: 549001
QUARTER: 1
YEAR: 2010

Certified With Comments

Ken approved on 11-24-10 everything looks good. TPM

PROVIDER: Seton Highland Lakes
THCIC ID: 559000
QUARTER: 1
YEAR: 2010

Certified With Comments

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

PROVIDER: Palacios Community Medical Center
THCIC ID: 574001
QUARTER: 1
YEAR: 2010

Certified With Comments

We are aware of the patient race errors and are in communication with HealthLand to resolve future errors.

PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Round Rock Medical Center
THCIC ID: 608000
QUARTER: 1
YEAR: 2010

Certified With Comments

- Inpatient discharge data have been collected from claims data. The data are used for billing purposes and are not clinical data. Due to the diversity of healthcare organizations and data collecting practices throughout Texas, there are inherent limitations on comparing outcomes.
- The public data file does not contain all the diagnosis and procedure codes. This will affect the volume of procedures, the severity adjustment and mortality rates.
- The data reflect only those patients admitted to a hospital during the year and are aggregated, not trended. Data over time are needed for a more accurate assessment of the health care facilities performance.
- THCIC has excluded data when five or fewer patients had a procedure and did not perform statistical analysis when there were fewer than 30 patients.
- Race/Ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.

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PROVIDER: Memorial Hermann Sugar Land
THCIC ID: 609001
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient

has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: Memorial Hermann The Woodlands Hospital
THCIC ID: 615000
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest
THCIC ID: 627000
QUARTER: 1
YEAR: 2010

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
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: Baylor Institute for Rehab-Gaston Episcopal Hosp
THCIC ID: 642000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 1
YEAR: 2010

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
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: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
QUARTER: 1
YEAR: 2010

Certified With Comments

Results may not be 100% accurate

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PROVIDER: Trinity Mother Frances Rehab Hospital
THCIC ID: 692000
QUARTER: 1
YEAR: 2010

Certified With Comments

Some data elements have been accepted "as is" and may marginally affect accuracy of the report.

==========
PROVIDER: Corpus Christi Medical Center-Bay Area
THCIC ID: 703000
QUARTER: 1
YEAR: 2010

Certified With Comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

Consolidation efforts for all women's and OB services to be located at Corpus Christi Medical Center's Women's Center at Bay Area were completed in May 2005.

==========
PROVIDER: Corpus Christi Medical Center-Doctors Regional
THCIC ID: 703002
QUARTER: 1
YEAR: 2010

Certified With Comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

Consolidation efforts for all women's and OB services to be located at Corpus Christi Medical Center's Women's Center at Bay Area were completed in May 2005.

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PROVIDER: Corpus Christi Medical Center-Heart Hospital
THCIC ID: 703003
QUARTER: 1
YEAR: 2010

Certified With Comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

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PROVIDER: Corpus Christi Medical Center-Northwest
THCIC ID: 704004
QUARTER: 1
YEAR: 2010

Certified With Comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

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PROVIDER: Our Childrens House Baylor
THCIC ID: 710000
QUARTER: 1
YEAR: 2010

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.

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PROVIDER: Ennis Regional Medical Center
THCIC ID: 714500
QUARTER: 1
YEAR: 2010

Certified With Comments

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

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PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 1
YEAR: 2010

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
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: Methodist Willowbrook Hospital
THCIC ID: 724700
QUARTER: 1
YEAR: 2010

Certified With Comments

The 2010-Q1 Outpatient data is understated by about 450 records which errored out incorrectly and failed to be submitted.

==========

PROVIDER: Baylor Heart & Vascular Center
THCIC ID: 784400
QUARTER: 1
YEAR: 2010

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: LifeCare Hospital-Plano
THCIC ID: 789800
QUARTER: 1
YEAR: 2010

Certified With Comments

Unable to replicate data in order to confirm.

Cheryl Carse, RN, MSN
Director Quality Management
LifeCare Hospital of Plano

==========

PROVIDER: Texas Orthopedic Hospital
THCIC ID: 792000
QUARTER: 1
YEAR: 2010

Certified With Comments

Certify without comments.

==========

PROVIDER: St Lukes Community Medical Center-The Woodlands
THCIC ID: 793100
QUARTER: 1
YEAR: 2010

Certified With Comments

The data reports for Quarter 1, 2010 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 registrations and billing data.

==========

PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
QUARTER: 1
YEAR: 2010

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.

Thanks,
Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals
512-324-1000 x10245

==========

PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
QUARTER: 1
YEAR: 2010

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.

Thanks,
Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals
512-324-1000 x10245

==========

PROVIDER: Lubbock Heart Hospital
THCIC ID: 801500
QUARTER: 1
YEAR: 2010

Elected Not to Certify

The information is so voluminous that I cannot accurately assess the information with 100% accurancy.

==========

PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
QUARTER: 1
YEAR: 2010

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: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 1
YEAR: 2010

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
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.
Patient Charges
Texas Health Denton identified an issue surrounding patient charges for March 2010. This issue could not be corrected before the data was submitted.

==========
PROVIDER: Methodist Sugar Land Hospital
THCIC ID: 823000
QUARTER: 1
YEAR: 2010

Certified With Comments

The 2010-Q1 Outpatient data is understated by about 435 records which errored out incorrectly and failed to be submitted.

==========
PROVIDER: Heart Hospital Baylor Plano
THCIC ID: 844000
QUARTER: 1
YEAR: 2010

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: Texoma Medical Center
THCIC ID: 847000
QUARTER: 1
YEAR: 2010

Certified With Comments

Data Source. The source of this data 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 fewer the codes the less information is available to evaluate the patient's 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 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 patient's 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. Unless the payment is impacted, the hospitals 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: Memorial Hermann Northeast
THCIC ID: 847100
QUARTER: 1
YEAR: 2010

Certified With Comments

The Certification Files reveal the below two issues. Memorial Hermann is following the THCIC submission requirements, so these are issues resulting from those requirements.

1) Some of our patients have a length of stay of up to 30 days because they are recurring out patients.....they are receiving ongoing treatment of some kind and so they are set up to receive only one comprehensive bill per 30 days. If one of the THCIC outpatient revenue codes is included in their services during the month, then the patient is included in the submission and the patient has a length of stay up to 30 days.
2) Because specialty room and treatment room revenue codes are included in the THCIC revenue list, patients are included in the submission that have one of these revenue codes but may be neither an ambulatory surgery or radiology patient.

==========

PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
QUARTER: 1
YEAR: 2010

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.

Thanks,
Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals
512-324-1000 x10245

==========

PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
QUARTER: 1
YEAR: 2010

Certified With Comments

This is the second set of data for 1st QTR 2010. First Data was certified September 1, 2010

==========

PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
QUARTER: 1
YEAR: 2010

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.

Thanks,
Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals
512-324-1000 x10245

==========

PROVIDER: TrustPoint Hospital
THCIC ID: 865800
QUARTER: 1
YEAR: 2010

Elected Not to Certify

DATA HAS "FACE VALIDITY" BUT FORMAL LINE-BY-LINE REVIEW HAS NOT BEEN COMPLETED.

==========

PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
QUARTER: 1
YEAR: 2010

Certified With Comments

The data reports for Quarter 1, 2010 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 registrations and billing data.

==========

PROVIDER: Coastal Bend Ambulatory Surgical Center
THCIC ID: 147001
QUARTER: 1
YEAR: 2010

Certified With Comments

Reports for 2010 first quarter indicate patient age breakdown category of 4.76% for age less than one year. This is not correct for this facility as it does not treat patients in this age group. This indication must be a result of data error.

==========

PROVIDER: Elm Place Ambulatory Surgical Center
THCIC ID: 166000
QUARTER: 1
YEAR: 2010

Elected Not to Certify

I do not certify the data for the first quarter 2010.
I was misinformed by the vendor System 13 regarding the direction to enter the data
under the designation of Out Patient-professional. Evidently now,
I am told by the state that it should have been entered under Out Patient-Institutional
to encompass Medicaid, Medicare and insurance based entities.

Additionally there were errors in two areas on the data submitted:
Many charges were coded in a way that did not reflect the actual charges when the reports were reviewed and the state believes that this may have been due to decimal points in incorrect locations.
The amounts shown as charges reflect a totally inaccurate profile of actual charges.
This data cannot be changed at this point according to the State.
Also there were problems with the correlation between ICD-9 codes correlating with
CPT codes that result in inaccurate results in review of diagnoses and procedures.

==========

PROVIDER: Fort Worth Surgery Center
THCIC ID: 121001
QUARTER: 1
YEAR: 2010

Certified With Comments

AFTER CERTIFICATION IT WAS NOTED THAT THE RACE HAD NOT BEEN LOADED CORRECTLY IN OUR SYSTEM. THE SYSTEM REFLECTS THAT WE HAVE DONE A LARGE AMERICAN INDIAN/ESKIMO POPULATION INSTEAD OF WHITE. WE HAVE TAKEN STEPS TO RE-MAP AND CORRECT THE SITUATION. WHEN REVIEWING THE DATA FOR 1ST QUARTER PLEASE DO NOT USE THE RACE STATISTICS.
==========

PROVIDER: Howerton Surgical Center
THCIC ID: 233000
QUARTER: 1
YEAR: 2010

Certified With Comments

Events entered.

==========

PROVIDER: South Austin Surgery Center
THCIC ID: 262001
QUARTER: 1
YEAR: 2010

Certified With Comments

We are 77% below are expected. Reason being is that alot of our commonly used CPT codes were not checked off as being a required CPT code for State Reporting. That has been fixed now and should start looking better moving forward.

==========

PROVIDER: The Center for Sight
THCIC ID: 272000
QUARTER: 1
YEAR: 2010

Certified With Comments

Patient Age Breakdown shows 4 patients less than 1 year of age. We do not perform surgery on patients under 18 years of age.

==========

PROVIDER: West Houston Surgicare
THCIC ID: 318002
QUARTER: 1
YEAR: 2010

Certified With Comments

The certifier now is Vanessa Cardenas vcardenas@uspi.com phn#713-461-3547 fax#713-722-8921. Sharon Kossmann is no longer with the company.

==========

PROVIDER: Bay Area Endoscopy Center
THCIC ID: 328000
QUARTER: 1
YEAR: 2010

Certified With Comments

Vendor software for submitting had errors. Unable to make corrections to claims at this time. The following changes have been made for future submissions.

- Corrected format of data submitted for foreign patients
- Corrected lack of provider info by reporting an "other" provider as required in the THCIC spec
- Improved detection of partial or invalid SSN's

- Properly calculate total charges for Medicare patients by excluding charges not covered by Medicare
- Exclude voided visits

==========

PROVIDER: Physicians Surgicenter Houston True Results
THCIC ID: 364000
QUARTER: 1
YEAR: 2010

Certified With Comments

There may be some claims accidentally excluded due to start up issues.

==========

PROVIDER: Amarillo Cataract & Eye Surgery Center
THCIC ID: 694600
QUARTER: 1
YEAR: 2010

Certified With Comments

Hopefully from the last quarter that was certified, the deletion of the individual patient's name has been coreected. The 1st quarter of 2010 has not shown that.

==========

PROVIDER: Central Park Surgery Center
THCIC ID: 712100
QUARTER: 1
YEAR: 2010

Certified With Comments

On any physicians NPI errors. I personally called and verified we had correct NPI number

==========

PROVIDER: Texas Midwest Surgery Center
THCIC ID: 718200
QUARTER: 1
YEAR: 2010

Certified With Comments

Data states 478 Medicare Part A claims. These should be Medicare Part B claims. It is a error with our software system.

==========

PROVIDER: Doctors Surgical Center
THCIC ID: 721500
QUARTER: 1
YEAR: 2010

Certified With Comments

1q10 is certified without comments.

==========

PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
QUARTER: 1
YEAR: 2010

Certified With Comments

AS IS

==========

PROVIDER: Summit Ambulatory Surgery Center
THCIC ID: 725300
QUARTER: 1
YEAR: 2010

Certified With Comments

All data has been reviewed and is correct. Please certify data.
Thank You.

==========

PROVIDER: Piney Point Surgery Center
THCIC ID: 728100
QUARTER: 1
YEAR: 2010

Certified With Comments

The following Event IDs should be empty claims:
120101429685

==========

PROVIDER: Amarillo Endoscopy Center
THCIC ID: 779002
QUARTER: 1
YEAR: 2010

Certified With Comments

on the patients by other physicians the physician's name listed is mispelled.

==========

PROVIDER: Good Shepherd Ambulatory Surgical Center
THCIC ID: 779200
QUARTER: 1
YEAR: 2010

Certified With Comments

Applicable to Medicare Part B Only.

Discrepancy in data transmission of insurance fields.

==========

PROVIDER: HEB Surgical Oncology Center
THCIC ID: 781700

QUARTER: 1
YEAR: 2010

Elected Not to Certify

Our IT system was just upgraded and previous data may be inaccurate.

==========

PROVIDER: Med Center Ambulatory Surgery
THCIC ID: 789700
QUARTER: 1
YEAR: 2010

Certified With Comments

Claim filing indicator codes did not download correctly.

==========

PROVIDER: Memorial Endoscopy Center
THCIC ID: 790700
QUARTER: 1
YEAR: 2010

Certified With Comments

Error: Please note this file has data from the last quarter of 2009 and the first quarter of 2010.

==========

PROVIDER: Wilson Surgicenter
THCIC ID: 792800
QUARTER: 1
YEAR: 2010

Certified With Comments

There was one claim in this data set that was missing the unit measurement code for the q1003 lens implant. It should have been listed as one "unit". This was a data entry error.

==========

PROVIDER: Surgery Center of Richardson
THCIC ID: 803700
QUARTER: 1
YEAR: 2010

Certified With Comments

There may be approximately 100 records inadvertently excluded due to start up issues.

==========

PROVIDER: Medical Village Surgery Center
THCIC ID: 804300
QUARTER: 1
YEAR: 2010

Certified With Comments

Upon review there are TWO cases in which a pain management doctor was entered in lieu of an orthopedic surgeon.

==========

PROVIDER: Headache & Pain Ambulatory Surgery Center
THCIC ID: 809900
QUARTER: 1
YEAR: 2010

Certified With Comments

THCIC Report C01: Certification Summary
Patient age breakdown indicates that there were 11 patients less than 1 year old. This data was entered in error and there should be 4 patients added to the 18-44 age range; 5 patients added to the 45-64 age range; and 2 patients added to the 65-74 age range

THCIC Outpatient-Institutional Report C04: Top 30 Principal Diagnoses Q1 2010
Diagnosis code 7213 indicates there was 1 patient Under 1. This data was entered in error and there should be a total of 95 patients listed in the 45-64 age range. Diagnosis code 7246 indicates there were 3 patients Under 1. The corrected data should read 31 in the18-44 age range and 67 in the 45-64 age range. Diagnosis code 72210 indicates there were 4 patients Under 1. The corrected data should read 31 in the 18-44 age range; 46 in the 45-64 age range, and 40 in the 65-74 age range. Diagnosis code 7211 indicates there was 1 patient Under 1. The corrected data should have 37 in the 45-64 age range. Diagnosis code 7212 indicates there was 1 patient Under 1. The corrected data should have 7 patients in the 65-74 age range. Diagnosis code 7234 indicates there was 1 patient Under 1. The corrected data should have 6 patients in the 45-64 age range.

THCIC Duplicate Events Summary Report-Outpatient
Noted that one patient had different patient control numbers but the same date of service. The date of service was entered in error.

Noted that one patient was entered twice with the same date of service. The patient control numbers were entered in error.

THCIC Outpatient- Institutional Report C08: Patients by Operating Physician Q1 2010
Noted that two doctors names were spelled incorrectly multiple times. However, the NPI number was correct on all claims

==========

PROVIDER: Foundation West Houston Surgical Center
THCIC ID: 810500
QUARTER: 1
YEAR: 2010

Certified With Comments

This data has been reviewed to the best of our ability; current software did not accommodate insurance types correctly. This will be corrected in future uploads. Data certified for Administrator Chris Riedel R.N. by Ann Elahi business office manager.

==========

PROVIDER: Baylor Ambulatory Endoscopy Center
THCIC ID: 813600

QUARTER: 1
YEAR: 2010

Certified With Comments

The claim accuracy report is 100%

==========

PROVIDER: Specialty Surgery Center of Fort Worth
THCIC ID: 814700
QUARTER: 1
YEAR: 2010

Certified With Comments

There may be some claims inadvertently excluded due to start up issues.

==========

PROVIDER: Spine Team Texas ASC
THCIC ID: 816200
QUARTER: 1
YEAR: 2010

Certified With Comments

We have a few files that filed to the state that should not have. The patients rescheduled so a lot of the fields were blank. We're working on a solution to this. KB

==========

PROVIDER: Spinecare
THCIC ID: 816900
QUARTER: 1
YEAR: 2010

Certified With Comments

Data generated by facility's scheduling and billing system. The facility cannot guarantee its accuracy due to possible data entry errors by users.

==========

PROVIDER: Park Hudson Surgery Center
THCIC ID: 824400
QUARTER: 1
YEAR: 2010

Certified With Comments

The first quarter is incomplete. This is the first time to enter this data.

==========

PROVIDER: Memorial Hermann Surgery Center Woodlands
THCIC ID: 825400
QUARTER: 1
YEAR: 2010

Certified With Comments

Data is complete

==========

PROVIDER: Doctors Surgery Center at Huguley
THCIC ID: 831600
QUARTER: 1
YEAR: 2010

Certified With Comments

Certified by Becky Hernandez

==========

PROVIDER: The Endoscopy Center of Texarkana
THCIC ID: 833600
QUARTER: 1
YEAR: 2010

Certified With Comments

certified by Glenda Cross

==========

PROVIDER: Turning Point Specialty Surgery Center
THCIC ID: 836100
QUARTER: 1
YEAR: 2010

Certified With Comments

There may be some claims inadvertently excluded due to start up issues.

==========

PROVIDER: ADC Endoscopy Specialist
THCIC ID: 837500
QUARTER: 1
YEAR: 2010

Certified With Comments

2 patients noted less than 17 years of age do not have DOB's we could obtain. Facility does not perform procedures on patients in this age range.

==========

PROVIDER: Mainland Surgery Center
THCIC ID: 837900
QUARTER: 1
YEAR: 2010

Certified With Comments

250 cases performed, according to software provider (SourceMedical) Upgrade will be available soon to correct this development problem

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PROVIDER: Simmons Ambulatory Surgery Center
THCIC ID: 843300

QUARTER: 1
YEAR: 2010

Certified With Comments

PROVIDER: Parkland Memorial Hospital - Simmons Ambulatory Surgical Center
THCIC ID: 843300
QUARTER: 1
YEAR: 2010

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 8,401 staff. Approximately 1,246 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: Medical Arts Surgery Center
THCIC ID: 849100
QUARTER: 1
YEAR: 2010

Elected Not to Certify

facility type code incorrect, working with networkers to fix

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PROVIDER: El Paso Center for Gastrointestinal Endoscopy
THCIC ID: 854900
QUARTER: 1
YEAR: 2010

Certified With Comments

the two error are because Mexico address

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PROVIDER: Cleburne Surgical Center
THCIC ID: 856000
QUARTER: 1
YEAR: 2010

Certified With Comments

This is my first file to certify. We had a 97.47% Accuracy rate. In the 1st quarter our system was not as easily able to capture ethinicity and race on all

patients. We at Cleburne Surgical Center strive to get to 100% on this report. I James McGehee certify that this data is CSCs data.

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PROVIDER: Corpus Christi Endoscopy Center
THCIC ID: 857300
QUARTER: 1
YEAR: 2010

Certified With Comments

I certify that the information submitted is complete and accurate

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PROVIDER: Spine Team Texas Rockwall ASC
THCIC ID: 902000
QUARTER: 1
YEAR: 2010

Certified With Comments

There were a few files that filed to the state that should not have. The patients appointments were rescheduled or canceled; therefore most of the fields would have been left blank. We are researching a fix for this problem. KB

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PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
QUARTER: 1
YEAR: 2010

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.

Thanks,
Patricia Kincheon
Clinical Quality & Patient Safety
Seton Family of Hospitals
512-324-1000 x10245

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PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 1
YEAR: 2010

Certified With Comments

The data reports for Quarter 1, 2010 do not accurately reflect patient volume or severity.

Patient Volume

Outpatient Facility Comments, 1Q2010

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 registrations and billing data.

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PROVIDER: MARC ASC
THCIC ID: 932000
QUARTER: 1
YEAR: 2010

Elected Not to Certify

This was our first trial sending in the data. This data cannot be certified as our computer system will not pull completed visits, but only billed visits. We are working through this problem and should be able to certify future information.