Inpatient Comments on 4th QUARTER 2018 Data

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

- Data are administrative data, collected for billing purposes, not clinical data.
- Data are submitted in a standard government format, the 837-format used for submitting billing data to payers. State specifications require the submission of additional data elements. These data elements include race and ethnicity. Because these data elements are not sent to payers and may not be part of the hospital's standard data collection process, there may be an increase in the error rate for these elements. Data users should not conclude that billing data sent to payers is inaccurate.
- Hospitals are required to submit the patient's race and ethnicity following categories used by the U. S. Bureau of the Census. This information may be collected subjectively and may not be accurate.
- Hospitals are required to submit data within 60 days after the close of a calendar QUARTER (hospital data submission vendor deadlines may be sooner). Depending on hospitals' collection and billing cycles, not all discharges may have been billed or reported. Therefore, data for each QUARTER may not be complete. This can affect the accuracy of source of payment data, particularly self-pay and charity categories, where patients may later qualify for Medicaid or other payment sources.
- Conclusions drawn from the data are subject to errors caused by the inability of the hospital to communicate complete data due to reporting form constraints, subjectivity in the assignment of codes, system mapping, and normal clerical error. The data are submitted by hospitals as their best effort to meet statutory requirements.

PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
QUARTER: 4
YEAR: 2018
Certified With Comments
This data is correct to the best of my knowledge as of this date of certification.

PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
QUARTER: 4
YEAR: 2018
Certified With Comments
The data included in this file is administrative, not clinical research data. Administrative data may not accurately represent the clinical details of a patient visit. This data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006001
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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PROVIDER: CHRISTUS Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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PROVIDER: Kindred Hospital-Dallas
THCIC ID: 028000
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 127 records are correctly reported.
Ernestine Marsh
Kindred Hospital

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PROVIDER: CHRISTUS Good Shepherd Medical Center-Longview
THCIC ID: 029000
QUARTER: 4
YEAR: 2018

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 Scott & White Medical Center Carrollton
THCIC ID: 042000
QUARTER: 4
YEAR: 2018

Certified With Comments

Carrollton 042000
4th Qtr 2018

One encounter with an 803 warning, consists of data from near duplicate claims where only one claim contained the correct data, and the duplicate could not be removed from the data.

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PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
QUARTER: 4
YEAR: 2018

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of July 12, 2019. 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
To meet the States submission deadline, approximately 30 days following the close of the calendar year QUARTER, we submit a snapshot of billed claims, extracted from our database. Any discharged patient encounters no billed by this cut-off date will not be included in the QUARTERly submission file sent in.

Diagnosis and Procedures

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed which can alter the true picture of a patient's hospitalization, sometimes significantly. Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using an ICD-10-CM effective 10-1-2015. This is mandated by the federal government and all hospitals must comply. The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-10-CM is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated. There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore, mortality ratios may be accurate for reporting standards but overstated.

Physician

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

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PROVIDER: Brownwood Regional Medical Center
THCIC ID: 058000
QUARTER: 4
YEAR: 2018

Certified With Comments

There was one SSN that could not be obtained.

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Provider: Goodall - Witcher Hospital
THCIC ID: 070000
QUARTER: 4
YEAR: 2018
Certified With Comments

Race information is being collected, but a software vendor error in reporting is not pulling the information. We are working with the vendor to correct.

Provider: Wilbarger General Hospital
THCIC ID: 084000
QUARTER: 4
YEAR: 2018
Certified With Comments
Corrections were made.

Provider: Montgomery County Mental Health Treatment Facility
THCIC ID: 100087
QUARTER: 4
YEAR: 2018
Certified With Comments
Total claim for 2018 4th Qtr is (90). One claim not showing due to billing type. Claim will show for 1st QTR 2019.

Provider: TMC Bonham Hospital
THCIC ID: 106001
QUARTER: 4
YEAR: 2018
Certified With Comments
The issue with the "race" crosswalk in the electronic health record has now been resolved. 4thQUARTER IP data was regenerated and re-submitted with corrected race information.

Provider: CHI St Lukes Health Baylor College of Medicine Medical Center
THCIC ID: 118000
QUARTER: 4
YEAR: 2018
Certified With Comments

The data reports for QUARTER 4, 2018 do not accurately reflect patient volume or severity.
Patient Volume

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

Severity

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

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PROVIDER: University Medical Center
THCIC ID: 145000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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PROVIDER: University Hospital
THCIC ID: 158000
QUARTER: 4
YEAR: 2018

Certified With Comments

University Hospital provides healthcare to a large population in Bexar county and other surrounded counties.

IP claim accuracy rate is 99.92% for Q4 2018.

OP claim accuracy rate is 99.47% for Q4 2018.

Data submitted by this facility has been corrected to the best of our ability to meet State requirements.

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PROVIDER: Las Palmas Medical Center
THCIC ID: 180000
QUARTER: 4
YEAR: 2018
Certified With Comments

This data is submitted in an effort to meet statutory requirements. It is administrative data not clinical data and is utilized for billing purposes. Conclusions drawn could be erroneous due to reporting constraints, subjectivity in assignment of codes, system mapping and normal clerical error. Diagnostic and procedural data may be incomplete due to data field limitations. The State data file may not fully represent all diagnoses treated or all procedures performed. Race and ethnicity data may be subjectively collected and may not provide an accurate representation of the patient population for a facility. It should also be noted that charges are not equal to actual payments received by the facility or facility costs for performing the service. Most errors occurring are due to incorrect country codes or zip codes assigned to foreign countries which are recognized in the correction/reporting software. These have been corrected to the best of my ability and resources, as well as the admission errors. There were also diagnosis errors that were corrected. The occurrence of these errors is questionable because the data was available at the time of hospital data download however the error stated that there was no diagnosis error.

This data is submitted as the best effort to meet statutory requirements.

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PROVIDER: Medical Center Hospital
THCIC ID: 181000
QUARTER: 4
YEAR: 2018

Certified With Comments

Certify

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data Content

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

The state requires us to submit inpatient claims, by QUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not
included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process
defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Laredo Medical Center
THCIC ID: 207001
QUARTER: 4
YEAR: 2018

Certified With Comments
Claims submitted in error for Mercy Ministries provider could not be corrected at this time due to Clinic unable to provide provider name for each claim instead of Clinic name for all claims. Currently working on fixing this issue. Claims submitted in error with missing diagnosis, system would not accept submitted the code provided. Currently working on process to make sure all claims are coded correctly and errors fixed appropriately.

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data Content

This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter. The state requires us to submit inpatient claims, byQUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant’s diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Wise Health System
THCIC ID: 254000
QUARTER: 4
YEAR: 2018

Certified With Comments

The data for 4Q2018 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

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

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PROVIDER: Wise Health System
THCIC ID: 254001
QUARTER: 4
YEAR: 2018

Certified With Comments

The data for 4Q2018 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.
Any claims errors generated for missing information for the Operating Physician or Invalid Value Codes are caused by system issue which did not affect the quality or accuracy of the claim data as it has been accepted and processed by the payer for reimbursement when appropriate.

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PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data Content

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

The state requires us to submit inpatient claims, by QUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

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

Length of Stay

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Admit Source data for Normal Newborn

When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/Revenue Codes

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Discharge Disposition

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PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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

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PROVIDER: Swisher Memorial Hospital
THCIC ID: 273000
QUARTER: 4
YEAR: 2018

Certified With Comments

In 4q2018 and the rest of 2018, there was an issue with our reporting of Patient
Race. This issue was both in our Inpatient and Outpatient data. Race Code 5, "Other", was used for 100% of our Inpatient and Outpatient data. This reporting error was the result of a software issue with our EHR, Cerner, that could not be corrected. To my knowledge, this issue did not only affect us, but all Cerner users. This software issue has been fixed for the 2019 year. Moving forward, I will pay closer attention to the "Summary Report" as I would have discovered this issue much earlier.

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**PROVIDER: Texas Health Presbyterian Hospital-Kaufman**

THCIC ID: 303000

**QUARTER**: 4

**YEAR**: 2018

Certified With Comments

Data Content

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

The state requires us to submit inpatient claims, by QUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures

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

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

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

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

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

Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn
Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

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

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**PROVIDER:** Del Sol Medical Center  
THCIC ID: 319000  
QUARTER: 4  
YEAR: 2018

Certified With Comments

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

This data is submitted as the best effort to meet statutory requirements.

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**PROVIDER:** Texas Health Harris Methodist Hospital Cleburne  
THCIC ID: 323000  
QUARTER: 4  
YEAR: 2018
Certified With Comments

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

The state requires us to submit inpatient claims, byQUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

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

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

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

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
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Cost/Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

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

================================================================================

PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 4
YEAR: 2018

Certified With Comments

BUMC 331000
4th QTR 2018
Certification Comment:

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

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**PROVIDER: Cook Childrens Medical Center**

THCIC ID: 332000  
QUARTER: 4  
YEAR: 2018

Certified With Comments

Cook Children's Medical Center has submitted and certified FOURTHQUARTER 2018 inpatient, outpatient surgery and outpatient radiology encounters to the Texas Health Care Information Council with the following possible data concerns based on the required submission method.

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

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

Comparative complication reports reflecting the above conditions could misstate the true conditions at Cook Children's Medical Center for the FOURTHQUARTER OF 2018.
There may be some encounters will have one of the following issues:

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

These are errors that are very difficult, if not impossible to correct as that is how they are sent to the respective payers.

Additionally, there may be outpatient encounters where there is an invalid NPI associated with the attending provider. These are most likely to be encounters in the ED where a patient was seen by a nurse in triage and charges were incurred, but left without being seen by a physician or an advanced nurse provider.

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

This will affect encounters for the FOURTHQUARTER OF 2018

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: Medical Arts Hospital
THCIC ID: 341000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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PROVIDER: Reagan Memorial Hospital
THCIC ID: 343000
QUARTER: 4
YEAR: 2018

Certified With Comments

CERTIFYING WITH CORRECTIONS MADE DUE TO SYSTEM SOFTWARE

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PROVIDER: Coryell Memorial Hospital
THCIC ID: 346000
QUARTER: 4
YEAR: 2018

Certified With Comments

There is a discrepancy in the number of discharges for the fourth QUARTER 2018.
Coryell Health had 194 discharges rather than the 157 which are included in this report.

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PROVIDER: Baylor Scott & White All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 4
YEAR: 2018

Certified With Comments

BSW All Saints Medical Center, 363000
4th QTR 2018

Certification Comment:
One encounter with an 803 warning, consists of data from near duplicate claims where only one claim contained the correct data, and the duplicate could not be removed from the data.

================================================================================

**PROVIDER: Nacogdoches Medical Center**  
THCIC ID: 392000  
QUARTER: 4  
YEAR: 2018  
Certified With Comments

We were notified of an issue with the SELF PAY payor source being incorrect, and have chosen not to make corrections at this time.

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**PROVIDER: Peterson Regional Medical Center**  
THCIC ID: 406000  
QUARTER: 4  
YEAR: 2018  
Certified With Comments

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

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

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

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

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 4
YEAR: 2018

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

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

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

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

Cost/Revenue Codes

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

Discharge Disposition

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

================================================================================
PROVIDER: Medina Regional Hospital
THCIC ID: 427000
QUARTER: 4
YEAR: 2018
Certified With Comments

Issue within EMR shows all patients with a race of "Other Race - 5". This has since been corrected.

================================================================================
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 4
YEAR: 2018
Data Content

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

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

Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be
creating guidelines for use by hospitals. These guidelines will provide better
clarity for the accurate collection of this data. Hospitals do not routinely
collect race and ethnicity as part of the admission process, that this has been
added to meet the THCIC requirement. Our admissions staff indicates that many
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Therefore, depending on the circumstances of the patient’s admission, race and
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data may not provide an accurate representation of the patient population for a
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Discharge Disposition

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PROVIDER: Connally Memorial Medical Center
THCIC ID: 433000
QUARTER: 4
YEAR: 2018

Certified With Comments

Race codes in this data file are not accurate. A mapping problem in the software used to generate the file caused almost all race codes to be defaulted to code 5
Other Race.

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PROVIDER: Frio Regional Hospital
THCIC ID: 441000
QUARTER: 4
YEAR: 2018

Certified With Comments

Or previous leadership/director is no longer here and we did not have the opportunity to train replacement and make corrections/finalize.

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PROVIDER: UT Southwestern University Hospital-Clements University
THCIC ID: 448001
QUARTER: 4
YEAR: 2018

Certified With Comments

E-617 Dates are correct

E-618 Dates are correct

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PROVIDER: Midland Memorial Hospital
THCIC ID: 452000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data submission errors have been identified and currently being address to corrected. Midland Memorial Hospital is in the process of working with the
software vendor used to create its submission files. This update correction will fix a K3 segment submission file creation error. This error pertains only to the patient social security number, when only reporting the patient social security number on the visit of a self-pay encounter - all other data load field segments are not affected.

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**PROVIDER:** DeTar Hospital-Navarro
THCIC ID: 453000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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

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

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

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

Diagnosis and Procedures

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission or
developed an infection during their hospitalization. This makes it difficult to
obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state’s data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-10-CM data on each patient but has limited the number of diagnoses
and procedures to the first 25 diagnoses codes and the first 25 procedure codes.
As a result, the data sent by us does meet state requirements but cannot reflect
all the codes an individual patient's record may have been assigned. This means
also that true total volumes may not be represented by the state's data file,
which therefore make percentage calculations inaccurate (i.e. mortality
percentages for any given diagnosis or procedure, percentage of patients in each
severity of illness category). It would be obvious; therefore, those sicker
patients (more diagnoses and procedures) are less accurately reflected by the
837 format. It then stands to reason that hospitals, which treat sicker
patients, are likewise less accurately reflected.

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

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Driscoll Childrens Hospital
THCIC ID: 488000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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PROVIDER: Ascension Seton Medical Center
THCIC ID: 497000
QUARTER: 4
YEAR: 2018
Seton Medical Center Austin has a transplant program and Neonatal Intensive Care Unit (NICU). Hospitals with transplant programs generally serve a more seriously ill patient, increasing costs and mortality rates. The NICU serves very seriously ill infants substantially increasing cost, lengths of stay and mortality rates. As a regional referral center and tertiary care hospital for cardiac and critical care services, Seton Medical Center Austin receives numerous transfers from hospitals not able to serve a more complex mix of patients. This increased patient complexity may lead to longer lengths of stay, higher costs and increased mortality.

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

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

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PROVIDER: Fort Duncan Regional Medical Center
THCIC ID: 547001
QUARTER: 4
YEAR: 2018

Certified With Comments

unable to correct missing patient country, patient state and zip code. going forward the claims will be corrected.

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

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

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

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

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

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

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
QUARTER: 4
YEAR: 2018

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

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

Diagnosis and Procedures

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

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

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

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

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

Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant’s diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

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

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

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

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

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**PROVIDER: Hamilton General Hospital**
THCIC ID: 640000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data certified as complete and accurate with all information available at time of reporting.

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**PROVIDER: Kindred Hospital-San Antonio**
THCIC ID: 645000
QUARTER: 4
YEAR: 2018
Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patients requiring a long hospitalization. Kindred hospital admissions are solely based on referrals from various health care settings, such as short-term acute care, skilled nursing, sub-acute, and in some cases direct admits from home. All referrals are screened by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 101 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

The state requires us to submit inpatient claims, by QUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming,
but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

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

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

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

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

Admit Source data for Normal Newborn
Texas Health Specialty Hospital does not have a newborn population.

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

Discharge Disposition

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

PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
QUARTER: 4
YEAR: 2018
Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 76 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data Content

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The state requires us to submit inpatient claims, byQUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual
hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

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

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

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

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

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

Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source.
Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

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

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

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

Discharge Disposition

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

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PROVIDER: Encompass Health Rehab Hospital Plano
THCIC ID: 670000
QUARTER: 4
YEAR: 2018

Certified With Comments

certified

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PROVIDER: Kindred Hospital-Houston Medical Center
THCIC ID: 676000
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long-term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as; short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. Therefore, all 205 records are correctly
Thank you,
Ernestine Marsh
Kindred Healthcare Southeast Region

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**PROVIDER:** Kindred Rehab Hospital Clear Lake  
**THCIC ID:** 680000  
**QUARTER:** 4  
**YEAR:** 2018

Certified With Comments

Kindred Hospital Rehab is a rehabilitation hospital that provides services for patients who are requiring rehab care. Kindred hospital admissions are sorely based on referrals from various health care settings; such as; short term acute care, skilled nursing; sub-acute and in cases direct admits from home. Therefore, all 212 records are correctly reported.

Thank you,
Ernestine Marsh
Kindred Hospital Southeast Region

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**PROVIDER:** Kindred Hospital-Tarrant County  
**THCIC ID:** 690000  
**QUARTER:** 4  
**YEAR:** 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referrals are screened by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 91 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: Kindred Hospital Houston NW  
THCIC ID: 706000  
QUARTER: 4  
YEAR: 2018  

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referrals are screened by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 138 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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Provided by: CHRISTUS St Michael Rehab Hospital
THCIC ID: 713001
QUARTER: 4
YEAR: 2018

Certified With Comments

To the best of my knowledge, the data submitted is accurate. I agree to certify.

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Provided by: Texas Health Seay Behavioral Health Hospital
THCIC ID: 720000
QUARTER: 4
YEAR: 2018

Certified With Comments

Data Content

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

The state requires us to submit inpatient claims, by QUARTER year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

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================================================================================

PROVIDER: Kindred Hospital Clear Lake
THCIC ID: 720402
QUARTER: 4
YEAR: 2018

Certified With Comments

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Ernestine Marsh
Kindred Hospital

================================================================================

PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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Diagnosis and Procedures

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

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

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Length of Stay

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

Admit Source data for Normal Newborn

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Race/Ethnicity

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

Cost/Revenue Codes

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

Discharge Disposition

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

================================================================================

**PROVIDER: Kindred Hospital El Paso**

THCIC ID: 727100

QUARTER: 4

YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 319 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
QUARTER: 4
YEAR: 2018

Certified With Comments

The data reports for QUARTER 4, 2018 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

================================================================================================
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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Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician’s subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient’s blood hemoglobin level falls below 9.5, another physician may
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The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

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

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

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

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

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

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

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

================================================================================
PROVIDER: New Braunfels Regional Rehab Hospital
THCIC ID: 786200
QUARTER: 4
YEAR: 2018
Minor errors were over-looked and not corrected.

PROVIDER: South Texas Spine & Surgical Hospital
THCIC ID: 786800
QUARTER: 4
YEAR: 2018

To the best of my knowledge, the data submitted is accurate. I agree to certify.

PROVIDER: Harlingen Medical Center
THCIC ID: 788002
QUARTER: 4
YEAR: 2018

None
Certified With Comments

To the best of my knowledge, the data submitted is accurate. I agree to certify.

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PROVIDER: Kindred Hospital Spring
THCIC ID: 792600
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 155 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: Kindred Hospital Tomball
THCIC ID: 792601
QUARTER: 4
YEAR: 2018
Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 137 records are correctly reported.

Ernestine Marsh
Kindred Hospital

PROVIDER: Kindred Hospital Sugar Land
THCIC ID: 792700
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 206 records are correctly reported.

Ernestine Marsh
Certified With Comments

The data reports for QUARTER 4, 2018 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

================================================================================

PROVIDER: Ascension Seton Southwest
THCIC ID: 797500
QUARTER: 4
YEAR: 2018
Certified With Comments

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

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

==================================================================================================

**PROVIDER: Ascension Seton Northwest**
THCIC ID: 797600
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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

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**PROVIDER: Kindred Hospital Tarrant County Fort Worth SW**
THCIC ID: 800000
QUARTER: 4
YEAR: 2018

Certified With Comments

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level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 213 records are correctly reported.

Ernestine Marsh
Kindred Hospital

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PROVIDER: Kindred Hospital-Fort Worth
THCIC ID: 800700
QUARTER: 4
YEAR: 2018

Certified With Comments

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Ernestine Marsh
Kindred Hospital

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PROVIDER: Kindred Hospital Bay Area  
THCIC ID: 801000  
QUARTER: 4  
YEAR: 2018

Certified With Comments

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Ernestine Marsh  
Kindred Hospital

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PROVIDER: Lubbock Heart Hospital  
THCIC ID: 801500  
QUARTER: 4  
YEAR: 2018

Certified With Comments

Physician's full name incorrect in EHR  IT is working on correcting  Dates are correct

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PROVIDER: Texas Health Harris Methodist Hospital Southlake  
THCIC ID: 812800  
QUARTER: 4  
YEAR: 2018
Certified With Comments

The Q4 2018 FILES for IP & OP for Race and Ethnicity were reviewed in detail and found to show a truer mix of patients we see at our facilities. The system issues in previous qtrs. have been addressed so there is no longer an automatic default in these categories. All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

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PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
QUARTER: 4
YEAR: 2018

Certified With Comments

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PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
QUARTER: 4
YEAR: 2018
Certified With Comments

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================================================================================

PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 4
YEAR: 2018

Certified With Comments

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PROVIDER: Westlake Medical Center
THCIC ID: 822800
QUARTER: 4
YEAR: 2018

Certified With Comments

errors due to transgender procedures do not match sex of patient

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PROVIDER: Hickory Trail Hospital
THCIC ID: 837800
QUARTER: 4
YEAR: 2018

Certified With Comments

Certified for Hickory Trail Hospital Business Office

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PROVIDER: El Paso LTAC Hospital
THCIC ID: 841300
QUARTER: 4
YEAR: 2018

Certified With Comments

I certify our data as correct... Thank You!

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PROVIDER: Baylor Scott & White The Heart Hospital Plano
THCIC ID: 844000
QUARTER: 4
YEAR: 2018

Certified With Comments

Heart Hospital Baylor Plano, 844000
4th QTR 2018

Certification Comment:

One encounter with an 803 warning, consists of data from near duplicate claims where only one claim contained the correct data, and the duplicate could not be removed from the data.

================================================================================

PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
QUARTER: 4
YEAR: 2018

Certified With Comments

Dell Children’s Medical Center of Central Texas (DCMCCT) is the only children's hospital in the Central Texas Region. DCMCCT serves severely ill and/or injured children requiring intensive resources which increase the hospital's costs of care, lengths of stay and mortality rates. In addition, the hospital includes a Neonatal Intensive Care Unit (NICU) which serves very seriously ill infants, which substantially increases costs of care, lengths of stay and mortality rates.
All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

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

=================================================================

PROVIDER: Foundation Surgical Hospital-San Antonio
THCIC ID: 852100
QUARTER: 4
YEAR: 2018

Certified With Comments

Our internal billing system is not pulling the admitting diagnosis, it is missing the segment on file 837. I am looking into resolving this issue for the next QUARTER data.

=================================================================

PROVIDER: Physicians Surgical Hospital-Quail Creek
THCIC ID: 852900
QUARTER: 4
YEAR: 2018

Certified With Comments

All data is correct to my knowledge with exception. Race is listed as other for partial files. Mapping error in EHR was corrected 11/2018

=================================================================

PROVIDER: Physicians Surgical Hospital-Panhandle Campus
THCIC ID: 852901
QUARTER: 4
YEAR: 2018
Certified With Comments

All data is correct to my knowledge with exception. Race is listed as other for partial files. Mapping error in EHR was corrected 11/2018

=====================================================================

**PROVIDER: Central Texas Rehab Hospital**
THCIC ID: 854400
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a Rehab care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization and rehab care. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 248 records are correctly reported.

Ernestine Marsh
Kindred Hospital

=====================================================================

**PROVIDER: Sagecrest Hospital Grapevine**
THCIC ID: 858200
QUARTER: 4
YEAR: 2018

Certified With Comments
Error Principal diagnosis code and Admitting diagnosis code was that the patient was not actually seen at our facility.

Claim filing indicator code should have been 837

Ethnicity was not given.

================================================================================================

**PROVIDER:** Texas Health Presbyterian Hospital-Rockwall
**THCIC ID:** 859900
**QUARTER:** 4
**YEAR:** 2018

Certified With Comments

The Q4 2018 FILES for IP & OP for Race and Ethnicity were reviewed in detail and found to show a truer mix of patients we see at our facilities. The system issues in previous qtrs. have been addressed so there is no longer an automatic default in these categories. All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

================================================================================================

**PROVIDER:** Ascension Seton Williamson
**THCIC ID:** 861700
**QUARTER:** 4
**YEAR:** 2018

Certified With Comments

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: SE Texas ER and Hospital
THCIC ID: 865900
QUARTER: 4
YEAR: 2018

Certified With Comments

certified

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PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
QUARTER: 4
YEAR: 2018

Certified With Comments

The data reports for QUARTER 4, 2018 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

================================================================================

PROVIDER: Kindred Hospital Dallas Central
THCIC ID: 914000
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 141 records are correctly reported.

Ernestine Marsh
Kindred Hospital

================================================================================

PROVIDER: Ascension Seton Hays
THCIC ID: 921000
QUARTER: 4
YEAR: 2018

Certified With Comments

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

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

================================================================================

PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 4
YEAR: 2018

Certified With Comments

The data reports for QUARTER 4, 2018 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

Everything has been corrected.

========================================================================

PROVIDER: Kindred Hospital The Heights
THCIC ID: 941000
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 155 records are correctly reported.

Ernestine Marsh
Kindred Hospital

========================================================================

PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
QUARTER: 4
YEAR: 2018
Certified With Comments

The Q4 2018 FILES for IP & OP for Race and Ethnicity were reviewed in detail and found to show a truer mix of patients we see at our facilities. The system issues in previous qtrs. have been addressed so there is no longer an automatic default in these categories. All data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, Bill type etc.

================================================================================

PROVIDER: Carrollton Springs
THCIC ID: 969500
QUARTER: 4
YEAR: 2018

Certified With Comments

All corrections have been made.

================================================================================

PROVIDER: Kindred Rehab Hospital Northeast Houston
THCIC ID: 969600
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a Rehabilitation hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization and rehab care. Kindred hospital admissions are solely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our
centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 141 records are correctly reported.

Ernestine Marsh
Kindred Hospital

================================================================================
PROVIDER: El Paso Childrens Hospital
THCIC ID: 969700
QUARTER: 4
YEAR: 2018

Elected Not to Certify

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

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

================================================================================
PROVIDER: Seton Medical Center Harker Heights
THCIC ID: 971000
QUARTER: 4
YEAR: 2018

Certified With Comments
It is correct to the best of my knowledge. I wish to certify this report.

=========================================================================

**PROVIDER:** Baylor Scott & White Medical Center McKinney 
THCIC ID: 971900  
QUARTER: 4  
YEAR: 2018

Certified With Comments

McKinney 971900  
4th QTR 2018

Certification Comment:

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

=========================================================================

**PROVIDER:** Texas Health Harris Methodist Hospital Alliance  
THCIC ID: 972900  
QUARTER: 4  
YEAR: 2018

Certified With Comments

Data Content

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

The state requires us to submit inpatient claims, byQUARTER year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge. If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance. The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

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

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

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

Discharge Disposition

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

PROVIDER: Mesa Springs
THCIC ID: 973430
QUARTER: 4
YEAR: 2018

Certified With Comments

The Q 4, 2018 data for ethnicity is incorrect. We are working on our system to be able to accurately report this statistic.

PROVIDER: Wise Health Surgical Hospital
THCIC ID: 973840
QUARTER: 4
YEAR: 2018

Certified With Comments
The data for 4Q2018 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

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

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PROVIDER: Texas Rehab Hospital of Arlington
THCIC ID: 974730
QUARTER: 4
YEAR: 2018

Certified With Comments

No errors

===============================================================================

PROVIDER: JPS Health Network - Trinity Springs North
THCIC ID: 975121
QUARTER: 4
YEAR: 2018

Certified With Comments

John Peter Smith Hospital (JPSH) is operated by JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission. In addition, JPSH holds Joint Commission accreditation as a hospital.
JPSH is the only Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only psychiatric emergency center in the county. The hospital's services include intensive care for adults and newborns, an AIDS treatment center, a full range of obstetrical and gynecological services, adult inpatient care and an inpatient mental health treatment facility.

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

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

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PROVIDER: Providence Hospital of North Houston
THCIC ID: 975152
QUARTER: 4
YEAR: 2018

Certified With Comments

certified

=================================================================
**PROVIDER: Methodist Southlake Hospital**
THCIC ID: 975153
QUARTER: 4
YEAR: 2018

Certified With Comments

No Comments

**PROVIDER: Kindred Hospital San Antonio Central**
THCIC ID: 975155
QUARTER: 4
YEAR: 2018

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 123 records are correctly reported.

Thank you

Ernestine Marsh

**PROVIDER: First Texas Hospital**
THCIC ID: 975166
QUARTER: 4
YEAR: 2018
Changes in our user management disabled our following up, timely, for claims correction. Issue has been resolved and will not impede future submissions.

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**PROVIDER: Texas Health Hospital Clearfork**

THCIC ID: 975167
QUARTER: 4
YEAR: 2018

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant’s diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health HEB recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

Discharge Disposition

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

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**PROVIDER:** Dell Seton Medical Center at The University of Texas  
THCIC ID: 975215  
QUARTER: 4  
YEAR: 2018

Certified With Comments

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

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

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

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

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

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PROVIDER: The Colony ER Hospital
THCIC ID: 975240
QUARTER: 4
YEAR: 2018

Certified With Comments

Certified

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PROVIDER: CHRISTUS Dubuis Hospital Beaumont
THCIC ID: 975255
QUARTER: 4
YEAR: 2018

Certified With Comments

No claim corrections noted for 4th QUARTER data.

=================================================================

PROVIDER: UT Health East Texas Carthage Hospital
THCIC ID: 975294
QUARTER: 4
YEAR: 2018

Certified With Comments

Unable to determine the cause for the error margin - they may be possibly business office related or due to private accounts not generating a UB claim form when claims data was resubmitted to our vendor.

=================================================================

PROVIDER: UT Health East Texas Henderson Hospital
THCIC ID: 975295
QUARTER: 4
YEAR: 2018
Unable to determine the cause for the error margin - they may be possibly business office related or due to private pay accounts not generating a UB claim form when claims data was resubmitted to our vendor.

=================================================================

**PROVIDER: UT Health East Pittsburg Hospital**
THCIC ID: 975297
QUARTER: 4
YEAR: 2018

Certified With Comments

Data is correct to the best of my knowledge.

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**PROVIDER: UT Health East Texas Quitman Hospital**
THCIC ID: 975298
QUARTER: 4
YEAR: 2018

Certified With Comments

This data is accurate to the best of my knowledge.

=================================================================

**PROVIDER: Wise Health Surgical Hospital**
THCIC ID: 975322
QUARTER: 4
YEAR: 2018

Certified With Comments
The data for 4Q2018 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THICIC; any changes would be information collected or updated during the normal course of business.

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

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PROVIDER: The Woodlands Integrative Care Hospital
THCIC ID: 975324
QUARTER: 4
YEAR: 2018

Certified With Comments

This was the first time we have reported due to the fact that we are a new facility and new to the whole reporting process. I have since taken training and understand all the information that must be reported on aQUARTERly basis. Unfortunately, at the time of 4thQUARTER, i was uninformed but tried to do to the best of my ability. I assure you going forward this will not be an issue.

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