General Comments on 3rd Quarter 2011 Data

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

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

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

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

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

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

==
PROVIDER: St Joseph Regional Health Center
THCIC ID: 002001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

St Joseph Regional Health Center uses TX 2400 format to do outpatient data submission through its vendor Thomson Reuters (http://thomsonreuters.com/).

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

User discretion is advised in using outpatient data for analysis purposes.

==
PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
 QUARTER: 3
    YEAR: 2011

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.

==
PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

==
PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

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

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

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

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

==
PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

===
PROVIDER: Madison St Joseph Health Center
THCIC ID: 041000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Madison St. Joseph Hospital uses TX 2400 format to do outpatient data submission
through its vendor Thomson Reuters (http://thomsonreuters.com/).

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

User discretion is advised in using outpatient data for analysis purposes.

===
PROVIDER: Baylor Medical Center at Carrollton
THCIC ID: 042000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

PROVIDER: Baylor Medical Center Carrollton
THCIC ID: 042000
QUARTER: 3
YEAR: 2011

Certified with comments

Submission Timing
Baylor estimates that our data volumes for the calendar year time period
submitted may include 96% to 100% of all cases for that time period.
The state requires us to submit a snapshot of billed claims, extracted
from our database approximately 20 days following the close of the calendar
year quarter. Any discharged patient encounters not billed by this cut-off
date will not be included in the quarterly submission file sent in.

Physician Identification
All physician license numbers and names have been validated as accurate
against a physician reference file that is derived from information provided
by the Texas Board of Medical Examiners. Those physicians not yet assigned
a state license number at the time of data submission are given temporary

numbers by the hospital for state reporting purposes. Due to the "lag"
time between when the physician is licensed and when THCIC receives the
information, some physicians may remain unidentified in the THCIC Practitioner
Reference Files.

The THCIC minimum data set houses only two (2) physician fields; Attending
Physician and Operating or Other Physician (if applicable) as reflected
on the UB92 billing document. Mortality rates, case costs and other data
calculated for this population of physicians may be misrepresentative.
Due to the complexity of most inpatient admissions many physicians provide
care to patients throughout an admission. Consulting physicians may prescribe
and treat patients on behalf of the physician listed as the attending
physician. Analysis of this physician information should carefully consider
that significant variations in case count, case cost, and mortality may
not be directly related to the care provided by the attending physician,
but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants)
for each case, THCIC maintains only one (1) additional physician per case
besides the Attending. "Other" physician case volumes, mortality, case
costs and LOS, will frequently be inaccurate because of this limitation.
Surgeons and consulting physicians beyond one that may have been involved
on a case will not be credited with providing care for that patient.
Analysis of "other physician" information should, therefore, take into
consideration that a significant portion of treating physicians are excluded
from the patient cases.

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-9-CM. This is mandated by the federal
government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and
are used by hospitals for billing purposes. The hospital can code as
many as 25 diagnoses and 25 procedures for each patient record. One limitation
of using the ICD-9-CM system is that there does not exist a code for every
possible diagnosis and procedure due to the continued evolution of medicine;
new codes are added yearly as coding manuals are updated.

Normal Newborns
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. The actual experience of a newborn is captured elsewhere in the
file, namely, in the ICD-9-CM diagnosis. Admission source does not give
an accurate picture.

Mortalities
Due to insurance payer requirements, organ donor patients are readmitted
and expired in the system to address the issues of separate payers. This
results in double counting some "expired" cases which will increase the
mortality figure reported and not accurately reflect the actual number
of mortalities.

Race/Ethnicity
There are no national standards regarding patient race categorization
so hospitals may not have the same designations from which patients can
choose. The state has recently attempted to standardize a valid set of
race codes for this project but these are not universally used by all
hospitals. Each hospital must independently map their specific codes
to the state's race code categories. This mapping may not be consistent
across hospitals. Thus epidemiology analysis of these two data fields
does not accurately describe the true population served by the hospital.

"Asian or Pacific Islander" encounters are not broken out separately
but are included in the "Other" race category.

Standard Source of Payment
The 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 identification must be categorized into the
appropriate standard source of payment value. It should also be noted that the
primary payer associated to the patient's encounter record might change over
time.

Additionally, 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.

Certification Process
Given the current certification software, there is not an efficient mechanism
to edit and correct the data. In addition, due to hospital volumes, it
is not feasible to perform encounter level audits and edits. 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.

==
PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of June 1, 2012. If any
errors are discovered in our data after this point, we will be unable to
communicate these due to THCIC. This data is administrative data, which
hospitals collect for billing purposes, and not clinical data, from which you
can make judgments about patient care.
Submission Timing
The State requires us to submit a snapshot of billed claims, extracted from our
database approximately 20 days following the close of the calendar year quarter.
Any discharged patient encounters not billed by this cut-off date will not be
included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed which can alter the true picture of a patient's
hospitalization, sometimes significantly.
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using ICD-9-CM and CPT. This is mandated by the federal government and
all hospitals must comply.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code as many as 25

diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM and CPT is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.
There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore mortality ratios may be accurate for reporting standards but overstated.
Physician
While the hospital documents many treating physicians for each case, the THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians. Many physicians provide care to patients throughout a hospital stay. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Analysis of "Other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.
Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. To meet the state's mandates to submit hospital Outpatient visits with specific procedures, Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format. All known errors have been corrected to the best of our knowledge. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

==
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The data reports for Quarter 3, 2011 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

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

==
PROVIDER: Memorial Hermann Southeast Hospital
THCIC ID: 119000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

===
PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

===
PROVIDER: TIRR Memorial Hermann
THCIC ID: 164000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

===
PROVIDER: Memorial Hermann Northwest Hospital
THCIC ID: 172000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

===
PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard
government format called
HCFA 837 EDI electronic claim format. Then the state specifications require
additional data elements to be
included over and above that. Adding those additional data places programming
burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur
due to this additional

programming, but the public should not conclude that billing data sent to our payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data
submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.

Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
03/22/12
4
race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

===
PROVIDER: Select Specialty Hospital-Houston Heights
THCIC ID: 206003
 QUARTER: 3
    YEAR: 2011

Certified With Comments

From: Davis, Teresa (CEO\DVP)
Sent: Thursday, May 31, 2012 3:13 PM
To: Witt, Michael J.
Subject: RE: 2011 Q3 State Reporting Certification

Houston Heights Certifies.

Teresa L. Davis, CEO
Division Vice President
Select Specialty Hospital
1917 Ashland
Houston, TX   77008
(713)802-8160
713-817-2874 (cell)

===
PROVIDER: Select Specialty Hospital-Houston West
THCIC ID: 206004
 QUARTER: 3
    YEAR: 2011

Certified With Comments

From: Stephens, Sandra
Sent: Wednesday, May 30, 2012 9:56 AM
To: Witt, Michael J.
Subject: RE: 2011 Q3 State Reporting Certification

You can certify for Houston West.   Thanks!

===
PROVIDER: Laredo Medical Center
THCIC ID: 207001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Jim Veteto (HIM

===
PROVIDER: Medical Center-Plano
THCIC ID: 214000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Houston Northwest Medical Center
THCIC ID: 229000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

We certify without comments.

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive

outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard government format called
HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be
included over and above that. Adding those additional data places programming burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data
submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the

codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
03/22/12
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race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

==
PROVIDER: Care Regional Medical Center
THCIC ID: 239001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Errors due to the process of updating specs to be 5010 compliant.

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PROVIDER: Columbia Medical Center-McKinney
THCIC ID: 246000

      QUARTER: 3
         YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Wise Regional Health System
THCIC ID: 254001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Information is correct at time it was uploaded as this data is a snapshot and is
subject to change
Dawn Byrd RHIA, HIM Director, Wise Regional

==
PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard
government format called
HCFA 837 EDI electronic claim format. Then the state specifications require
additional data elements to be
included over and above that. Adding those additional data places programming
burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur
due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data
submission. This represents a rare event that is less than 1% of the encounter
volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM)
and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often
driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose
a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with

anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
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race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this

requirement, each payer
identifier must be categorized into the appropriate standard and non-standard
source of payment value.
These values might not accurately reflect the hospital payer information,
because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any
true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges.
It is important to note that
charges are not equal to actual payments received by the hospital or hospital
cost for performing the service.
Typically actual payments are much less than charges due to managed
care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost
to deliver the care that each
patient needs.

===
PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
 QUARTER: 3
    YEAR: 2011

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 our Performance Improvement process, we review the data and strive
to make changes to result in improvement.

===
PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

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

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

Patients and physicians consider many factors when making health care decisions

that are not available in administrative data. These include a patients
preference for life-sustaining treatments, functional status, and other factors.

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

===
PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to
analyze the data. Regarding the mandate to communicate the Certification
reports to physicians The State does not offer a secure mechanism for us to
communicate other than the hard copy reports. At this time, we as a hospital
are moving to limit or eliminate paper distribution and we do not have an
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decision-making. Quality improvement is not new; it is an on-going commitment.

===
PROVIDER: Memorial Hermann Memorial City Medical Center
THCIC ID: 302000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

===
PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive

outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard
government format called
HCFA 837 EDI electronic claim format. Then the state specifications require
additional data elements to be
included over and above that. Adding those additional data places programming
burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur
due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data
submission. This represents a rare event that is less than 1% of the encounter
volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM)
and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often
driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose
a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a
diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was
different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate
comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the
hospital and those occurring during hospitalization. For example, if a code
indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to
admission, or developed an
infection during their hospitalization. This makes it difficult to obtain
accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each
patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital
or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes
significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each
patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving
surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses
codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements
but cannot reflect all the

codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
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These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

===
PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive outpatient surgical or radiological

services, by quarter year, gathered from a form called an UB92, in a standard government format called
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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
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the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
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assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
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patient needs.

==
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Baylor Medical Center at BUMC OUTPATIENT DATA
THCIC ID: 331000
QUARTER: 3
YEAR: 2011

CERTIFIED WITH COMMENTS

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

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

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

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

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

==
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Cook Children's Medical Center has submitted and certified the 3rd QUARTER
2011 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
3rd QUARTER OF 2011.

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

The data structure allowed by THCIC erroneously assigns surgeons to surgical
procedures they did not perform. The data structure provided by THCIC
allows for one attending and one operating physician assignment. However,
patients frequently undergo multiple surgeries where different physicians
perform multiple procedures. Assigning all of those procedures to a single

'operating physician' will frequently attribute surgeries to the wrong
physician. THCIC chooses to only assign one surgeon to a patient encounter,
not to each procedure.

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

==
PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: UMCB Comments

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

UMCB has a perinatal program that serves a population that includes mothers
with late or no prenatal care. It is also a regional referral center,
receiving patient transfers from hospitals not able to serve a complex
mix of patients. Treatment of these very complex, seriously ill patients
increases the hospital's cost of care, length of stay and mortality rates.

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

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

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

==
PROVIDER: Denton Regional Medical Center
THCIC ID: 336001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==
PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==
PROVIDER: Memorial Hermann Hospital
THCIC ID: 347000
 QUARTER: 3
     YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

==
PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 3
     YEAR: 2011

Certified With Comments

Baylor Medical Center at ASFW OUTPATIENT DATA
THCIC ID: 363000
QUARTER: 3
YEAR: 2011

CERTIFIED WITH COMMENTS

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

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

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

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

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

==
PROVIDER: Baylor Medical Center-Southwest Fort Worth
THCIC ID: 363001
 QUARTER: 3
     YEAR: 2011

Certified With Comments

Baylor Medical Center at SWFW OUTPATIENT DATA
THCIC ID: 363001
QUARTER: 3
YEAR: 2011

CERTIFIED WITH COMMENTS

Due to the sheer volume of OP data, we have limited resources as a hospital to
analyze the data. Regarding the mandate to communicate the Certification
reports to physicians The State does not offer a secure mechanism for us to
communicate other than the hard copy reports. At this time, we as a hospital
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===
PROVIDER: Medical Center-Lewisville
THCIC ID: 394000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

===
PROVIDER: Memorial Hermann Southwest Hospital
THCIC ID: 407000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

===
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

JPS Health Network
Comments on THCIC Data Submission
For
3rd Quarter 2011

Introduction

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

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

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

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

===
PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
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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
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Length of Stay
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any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
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Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
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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.

===
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological
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physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing

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

==
PROVIDER: North Hills Hospital
THCIC ID: 437000
 QUARTER: 3
     YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==
PROVIDER: UT Southwestern University Hospital-St Paul
THCIC ID: 448001
 QUARTER: 3
     YEAR: 2011

Certified With Comments

Abstracting error identified by physician, corrected after submission deadline.

==
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 3
     YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.

Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard
government format called
HCFA 837 EDI electronic claim format. Then the state specifications require
additional data elements to be
included over and above that. Adding those additional data places programming
burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur
due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These
errors have been corrected to the best of our knowledge.
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submission. This represents a rare event that is less than 1% of the encounter
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universal standard called the International Classification of Disease (ICD-9-CM)
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Terminology Codes (CPT Codes). This is mandated by the federal government. The
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the guidelines for assigning these diagnosis codes; however, this is often
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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
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anemia until their blood hemoglobin level is below 9.0. In both situations, a
diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was
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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
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purposes. The hospital can code up to 99 diagnoses and 99 procedures for each
patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving
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Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

==
PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified with comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894.

The Parkland System is a $995 million enterprise that is licensed for 968 beds and
employs approximately 8,204 staff.   86,688 patients received outpatient care in the
clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

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

==
PROVIDER: Plaza Medical Center-Fort Worth
THCIC ID: 477000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==
PROVIDER: Seton Medical Center
THCIC ID: 497000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: SMCA Comments

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

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

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

==
PROVIDER: Medical Center-Arlington
THCIC ID: 502000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==
PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Seton Highland Lakes, a member of the Seton Family of Hospitals, is a 25-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 clinics 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 Organization under its Critical Access designation
program.

==
PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Seton Edgar B. Davis, a member of the Seton Family of Hospitals, is a general
acute care; 25-bed facility committed to providing quality inpatient and
outpatient services for residents of Caldwell and surrounding counties.

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

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

==
PROVIDER: Memorial Hermann Sugar Land
THCIC ID: 609001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included

procedure codes but excluded HCPCS codes.

==
PROVIDER: Memorial Hermann The Woodlands Hospital
THCIC ID: 615000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

==
PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
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accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive
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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
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programming, but the public should not conclude that billing data sent to our
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If a medical record is unavailable for coding the encounter is not billed and is
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Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
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the guidelines for assigning these diagnosis codes; however, this is often
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criteria for defining a diagnosis. For example, while one physician may diagnose
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apples comparison cannot be made, which makes it difficult to obtain an accurate
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The codes also do not distinguish between conditions present at the time of the patient's admission to the
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Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
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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
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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

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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.
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of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

===
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
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accurately represent the clinical details of an encounter.
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services, by quarter year, gathered from a form called an UB92, in a standard government format called
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Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
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===
PROVIDER: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
  QUARTER: 3
     YEAR: 2011

Certified With Comments

Results may not be 100% accurate.

===
PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
  QUARTER: 3
     YEAR: 2011

Certified With Comments

Burleson St. Joseph Hospital Center uses TX 2400 format to do outpatient data
submission through its vendor Thomson Reuters (http://thomsonreuters.com/).

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

User discretion is advised in using outpatient data for analysis purposes.

===
PROVIDER: Physicians Centre Hospital
THCIC ID: 717500
  QUARTER: 3
     YEAR: 2011

Certified With Comments

Due to software issues unable to do correct errors prior to cutoff date for
corrections

===
PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
  QUARTER: 3

        YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive outpatient surgical or radiological
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Typically actual payments are much less than charges due to managed
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of payment by insurance companies. Charges also do not reflect the actual cost
to deliver the care that each
patient needs.

===
PROVIDER: Methodist Willowbrook Hospital
THCIC ID: 724700
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The 2011-Q3 data is understated by 312 records that errored out incorrectly and failed to be submitted.

==
PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Grimes St. Joseph Hospital uses TX 2400 format to do outpatient data submission through its vendor Thomson Reuters (http://thomsonreuters.com/).

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

User discretion is advised in using outpatient data for analysis purposes.

==
PROVIDER: Green Oaks Hospital
THCIC ID: 766000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Per the Corporate State Reporting and HSC teams:
Prior to 4th Quarter 2011 data, our data source for reporting of DFWHC data was the billing file provided by the SSC. We changed our data source effective with 4th quarter 2011 data to the Casemix database, which is fed with final billed data from the Meditech and HOST/PA systems. The billing file is subject to billing edits to ensure payment from the various payers. The Casemix database is not subject to the billing edits and provides a more accurate reflection of the data since no billing edits are involved.
As was disclosed from the Dallas SSC billing department and Green Oaks Hospital, when the facility bills a payer for revenue code 459(Other Emergency Room) a billing edit changes the code to revenue code 762 (Observation Hours) to ensure payment from payers. We were pulling billing data for 3rd Quarter 2011, the program extracted the revenue code 459 as revenue code 762 and reported the data to DFWHC who then processed it to THCIC.

Revenue code 762 is a reportable revenue code from THCIC, but revenue code 459 is not a reportable revenue code to THCIC. When the billing edit changed the revenue code from 459 to 762, these discharges went from a non-reportable discharges to reportable discharges and were submitted to THCIC. This change of revenue code did not happen in the data that was pulled from the Casemix database, which is not subject to billing edits.

A review of the 3rd Quarter 2011 OP Billing file vs Casemix data file found the reported numbers decreased from 1,986 claims from the billing file, to 0 (zero) eligible claims from the Casemix file.

Green Oaks 3rd Quarter 2011 submitted the corrected data to DFWHC 4/9/2012.
4/12/2012 DFWHC responded the data was ready for certification, however the
Parallon Payment process requires a hard check to be printed and mailed, which
did not allow enough time to process through the USPS for the 4/16/2012 3rd
Quarter 2011 resubmission deadline.

===
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified to the best of my knowledge.

===
PROVIDER: LifeCare Hospital-Plano
THCIC ID: 789800
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Unable to duplicate all data elements to certify.

Cheryl Carse, RN, MSN

===
PROVIDER: Kindred Hospital Spring
THCIC ID: 792600
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified by Mary Ann Craig, interim CEO

===
PROVIDER: Kindred Hospital Sugar Land
THCIC ID: 792700
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified by Lorene Perona, CEO

===
PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The data reports for Quarter 3, 2011 do not accurately reflect patient volume or

severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that
are a snapshot of claims that have been billed prior to the reporting deadline.
If the encounter has not yet been billed, data will not be reflected in this
quarter.

Severity

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

==
PROVIDER: Doctors Hospital-Renaissance
THCIC ID: 797100
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified but unable to correct errors due to technical difficulties.

==
PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: SSW Comments

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

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

==
PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: SNW Comments

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

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

==
PROVIDER: Lubbock Heart Hospital
THCIC ID: 801500
 QUARTER: 3
    YEAR: 2011

Elected Not to Certify

This information is so voluminous that I cannot accurately asses the information
with 100% accurancy.

==
PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

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

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

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

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

==
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard government format called
HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be
included over and above that. Adding those additional data places programming burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data
submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state

is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
03/22/12
4
race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

==
PROVIDER: Good Shepherd Medical Center-Linden
THCIC ID: 822100
 QUARTER: 3
    YEAR: 2011

Certified With Comments

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

==
PROVIDER: Methodist Sugar Land Hospital
THCIC ID: 823000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data is certified. There were 38 events that errored out.

==
PROVIDER: Memorial Hermann Rehab Hospital Katy
THCIC ID: 838400
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included
procedure codes but excluded HCPCS codes.

==
PROVIDER: University General Hospital
THCIC ID: 840200
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified with errors.

==
PROVIDER: Doctors Diagnostic Hospital
THCIC ID: 840400
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Did not collect Patient Location information at this time;

==
PROVIDER: Texoma Medical Center
THCIC ID: 847000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Source. The source of this data is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.
* The data file limits the diagnosis codes, the admission diagnosis and an E-code field.
* The procedure codes are limited.
* The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

Severity Adjustment.   THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
* The program can only use the codes available in the billing data file., If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the billing data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
* Not all claims may have been billed at this time.
* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

==
PROVIDER: Memorial Hermann Northeast
THCIC ID: 847100
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Memorial Hermann Outpatient Submissions prior to 2011 3rd Quarter included procedure codes but excluded HCPCS codes.

==
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: DCMC Comments

Dell Children's Medical Center of Central Texas (DCMCCT) is the only children's hospital in the Central Texas Region. DCMCCT serves severely ill and/or injured children requiring intensive resources which increases the hospital's costs of care, lengths of stay and mortality rates. In addition, the

hospital includes a Neonatal Intensive Care Unit (NICU) which serves very
seriously ill infants, which substantially increases costs of care, lengths
of stay and mortality rates.

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

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

==
PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: SMCW 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: TrustPoint Hospital
THCIC ID: 865800
 QUARTER: 3
    YEAR: 2011

Elected Not to Certify

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

==
PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The data reports for Quarter 3, 2011 do not accurately reflect patient volume or
severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that
are a snapshot of claims that have been billed prior to the reporting deadline.
If the encounter has not yet been billed, data will not be reflected in this
quarter.

Severity

Not all clinically significant conditions, such as the hearts ejection fraction,
can be captured and reflected in the various billing data elements including the

ICD-9-CM diagnosis coding system. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

==
PROVIDER: Abilene Cataract & Refractive Surgery Center
THCIC ID: 353001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

One claim requires a Social Security number which the patient does not have. He is a Mexican citizen visitng the country.

Claim # (REMOVED by THCIC)
Patient control # (REMOVED by THCIC)
MR # (REMOVED by THCIC).

==
PROVIDER: Amarillo Cataract & Eye Surgery Center
THCIC ID: 694600
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The records that were submitted from the 3rd quarter of 2011, contained an issue that I never could correct. Our patient control # is our medical record # and always has been. There was one submission that kept getting kicked back to me to correct. Never did solve that submission. Not sure why that happened.

==
PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
 QUARTER: 3
    YEAR: 2011

Certified With Comments

AS IS.

==
PROVIDER: Medical Village Surgery Center
THCIC ID: 804300
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Upon review there are two cases in which the procedure date was entered in lieu of the patients date of birth, four cases in which the wrong diagnosis code was entered, and two cases where the wrong charge was inadvertently entered for the procedure.

==
PROVIDER: Headache & Pain Ambulatory Surgery Center
THCIC ID: 809900

QUARTER: 3
YEAR: 2011

Certified With Comments

Frequency of Errors Report (Outpatient- Professional)

The following areas indicate that there are only 2 valid entries and 1356 that are Blank/Zero:

Rendering1 practitioner qual code
Rendering1 practitioner ID
Rendering1 practitioner last name
Rendering1 practitioner first name

This information is transmitted on the claims being sent to CMS. However, it is not in the specific line segment required in order for it to cross over electronically into the necessary fields. Our EMR and clearinghouse are working on a specific rule in order to correct the issue. It is expected to be corrected by 4th quarter 2011.

There was a missing social security number on a claim but the patient does not live in this country and therefore does not have a social security number.

===
PROVIDER: Foundation West Houston Surgical Center
THCIC ID: 810500
QUARTER: 3
YEAR: 2011

Certified With Comments

reviewed data to the best of our ability

===
PROVIDER: Spine Team Texas ASC
THCIC ID: 816200
QUARTER: 3
YEAR: 2011

Certified With Comments

No comments necessary

===
PROVIDER: Spinecare
THCIC ID: 816900
QUARTER: 3
YEAR: 2011

Elected Not to Certify

ELECT NOT TO CERTIFY

===
PROVIDER: Texas Endoscopy
THCIC ID: 818400

```
   QUARTER: 3
      YEAR: 2011
```

Certified With Comments

818400 and 818401 are the same facility. However, due to contractual
differences with certain payers, this facility needs two submitter ID#'s.


```
==============================================================================
PROVIDER: Centennial Surgery Center
THCIC ID: 820300
 QUARTER: 3
    YEAR: 2011
```

Certified With Comments

Q3 2011 Cert.


```
==============================================================================
PROVIDER: Dallas Endoscopy Center
THCIC ID: 826200
 QUARTER: 3
    YEAR: 2011
```

Certified With Comments

after spot checking a few patient account all accounts look to be accurate


```
==============================================================================
PROVIDER: Doctors Surgery Center at Huguley
THCIC ID: 831600
 QUARTER: 3
    YEAR: 2011
```

Certified With Comments

Certified by Rebecca Hernandez


```
==============================================================================
PROVIDER: Texas Health Outpatient Surgery Center Stephenville
THCIC ID: 838800
 QUARTER: 3
    YEAR: 2011
```

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard
government format called
HCFA 837 EDI electronic claim format. Then the state specifications require
additional data elements to be
included over and above that. Adding those additional data places programming
burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur

due to this additional
programming, but the public should not conclude that billing data sent to our payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data
submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that

this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
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4
race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

==
PROVIDER: Simmons Ambulatory Surgery Center
THCIC ID: 843300
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Certified with comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a $995 million enterprise that is licensed for 968 beds and employs approximately 8,204 staff. Approximately 1,686 patients received outpatient care in the clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

As in other large academic medical centers, teams of physicians rotating at intervals care for patients. The THCIC dataset allows only one primary physician to be assigned to the patient for the entire inpatient stay. In our

institution, this represents the physician caring for the patient at the time of
discharge. Many patients, particularly long-term care patients are actually
managed by as many as three to four different teams and attending physicians.
For this reason, the practice of attributing patient outcomes to the report card
of a single physician may result in misleading information.

==
PROVIDER: Babcock Surgical Center
THCIC ID: 867500
  QUARTER: 3
     YEAR: 2011

Certified With Comments

Need to check on insate out of state reports with software vendor.

==
PROVIDER: Spine Team Texas Rockwall ASC
THCIC ID: 902000
  QUARTER: 3
     YEAR: 2011

Certified With Comments

No comments.

==
PROVIDER: Laredo Digestive Health Center
THCIC ID: 904000
  QUARTER: 3
     YEAR: 2011

Certified With Comments

Discovered program issue on area of patient ethnicity , information generated
versts information received varies

==
PROVIDER: HEA Surgery Center
THCIC ID: 906000
  QUARTER: 3
     YEAR: 2011

Certified With Comments

Certified by Nancy King with $6,323.00 off due to system error.

==
PROVIDER: CHRISTUS Santa Rosa Physicians Ambulatory Surgery Center
THCIC ID: 917000
  QUARTER: 3
     YEAR: 2011

Certified With Comments

99.18%

==
PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Subject: SMCH 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: 3
    YEAR: 2011

Certified With Comments

The data reports for Quarter 3, 2011 do not accurately reflect patient volume or
severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that
are a snapshot of claims that have been billed prior to the reporting deadline.
If the encounter has not yet been billed, data will not be reflected in this
quarter.

Severity

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

==
PROVIDER: Texas Endoscopy
THCIC ID: 818401
 QUARTER: 3
    YEAR: 2011

Certified With Comments

818400 and 818401 are the same facility. However, due to contractual
differences with certain payers, this facility needs two submitter ID#'s.

==
PROVIDER: Memorial Hermann Surgery Center Richmond
THCIC ID: 934000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

One duplicated event to report.

==
PROVIDER: Corm Surgicenter
THCIC ID: 949000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

No comments!

==
PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
 QUARTER: 3
    YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological services, by quarter year, gathered from a
form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data places
programming burdens on the hospital since it is over and above the actual
hospital billing process. Errors can occur due to this additional programming,
but the public should not conclude that billing data sent to our payers is
inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes;
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission, or
developed an
infection during their hospitalization. This makes it difficult to obtain
accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be

incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99 diagnoses
and 99 procedures for each patient record. The state is requiring us to submit
ICD-9-CM / CPT data on each outpatient receiving surgical or radiological
services, but has limited the number of diagnoses and procedures to the first 25
diagnoses codes and the first 25 procedure codes. As a result, the data sent by
us does meet state requirements but cannot reflect all the codes an individual
patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is
only three characters long. Thus any patients discharged with a length of stay
greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is
not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be
creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate
collection of this data. Hospitals do not routinely collect race and ethnicity
as part of the admission process, that this has been added to meet the THCIC
requirement. Our admissions staff indicates that many patients are very
sensitive about providing race and ethnicity information. Therefore, depending
on the circumstances of the patient's admission, race and ethnicity data may be
subjectively collected. Therefore, the race and ethnicity data may not provide
an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data
required by the state that is not contained within the standard UB92 billing
record. In order to meet this requirement, each payer identifier must be
categorized into the appropriate standard and non-standard source of payment
value.
These values might not accurately reflect the hospital payer information,
because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any
true managed care comparisons by contract type (HMO vs. PPO) may result in
inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges.
It is important to note that
charges are not equal to actual payments received by the hospital or hospital
cost for performing the service.
Typically actual payments are much less than charges due to managed
care-negotiated discounts and denial of payment by insurance companies. Charges
also do not reflect the actual cost to deliver the care that each patient needs.

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PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
 QUARTER: 3
    YEAR: 2011

Certified With Comments

The data reports for Quarter 3, 2011 do not accurately reflect patient volume or
severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

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

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PROVIDER: JPS Surgical Center-Arlington
THCIC ID: 153300
 QUARTER: 3
    YEAR: 2011

Certified With Comments

JPS Health Network
Comments on THCIC Data Submission
For
3rd Quarter 2011

Introduction

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

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

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

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