General Comments on 3rd Quarter 2012 Data

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

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

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

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

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

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

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PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a $995 million enterprise that is licensed for 968 beds and employs approximately 9,071 staff. 89,540 patients received outpatient care in the clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

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

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PROVIDER: St Joseph Regional Health Center
THCIC ID: 002001
 QUARTER: 3
    YEAR: 2012

Certified With Comments

St Joseph Regional Health Center uses TX 2400 format to do outpatient data
submission through its vendor Truven Health (http://truvenhealth.com/), formerly
Thomson Reuters.
Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. St Joseph Regional Health Center
submits more than required outpatient discharges to Thomson Reuters, who then
converts the submitted outpatient records to 837 format and sends all submitted
outpatient records to THCIC data warehouse System 13 Inc
(https://thcic.system13.com). Unwanted outpatient records, defined as those
records containing non reportable revenue codes, are dropped by System 13, Inc.
User discretion is advised in using outpatient data for analysis purposes.

===
PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

===
PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

===
PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

===
PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

===
PROVIDER: Madison St Joseph Health Center
THCIC ID: 041000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Madison St. Joseph Hospital uses TX 2400 format to do outpatient data submission
through its vendor Truven Health (http://truvenhealth.com/), formerly Thomson
Reuters.
Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. Madison St. Joseph Hospital submits
more than required outpatient discharges to Thomson Reuters, who then converts
the submitted outpatient records to 837 format and sends all submitted
outpatient records to THCIC data warehouse System 13 Inc
(https://thcic.system13.com). Unwanted outpatient records, defined as those
records containing non reportable revenue codes, are dropped by System 13, Inc.
User discretion is advised in using outpatient data for analysis purposes.

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PROVIDER: Baylor Medical Center at Carrollton
THCIC ID: 042000
 QUARTER: 3
     YEAR: 2012

Certified With Comments

Baylor Medical Center Carrollton OUTPATIENT DATA
THCIC ID: 042000
QUARTER: 3
YEAR: 2012

CERTIFIED WITH COMMENTS

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

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PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
 QUARTER: 3
     YEAR: 2012

Elected Not to Certify

Due to the notification from THCIC, October 29, 2012 the THCIC Outpatient
Technical Specification Manual was previously incorrect and specific revenue
codes were unintentionally omitted from the manual, the Huguley Memorial Medical
Center Outpatient dataset may have discharges included from a prior
Certification quarter. THCIC merged the missing patient encounters back into
the correct quarterly dataset. If the user of this dataset is able to filter
the 3rd quarter discharges from this dataset, the data should be accurate.
The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of June 1, 2013. If any
errors are discovered in our data after this point, we will be unable to
communicate these due to THCIC. This data is administrative data, which
hospitals collect for billing purposes, and not clinical data, from which you
can make judgments about patient care.
Submission Timing
The State requires us to submit a snapshot of billed claims, extracted from our

database approximately 20 days following the close of the calendar year quarter.
Any discharged patient encounters not billed by this cut-off date will not be
included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed which can alter the true picture of a patient's
hospitalization, sometimes significantly.
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using ICD-9-CM and CPT. This is mandated by the federal government and
all hospitals must comply.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code as many as 25
diagnoses and 25 procedures for each patient record. One limitation of using
the ICD-9-CM and CPT is that there does not exist a code for every possible
diagnosis and procedure due to the continued evolution of medicine; new codes
are added yearly as coding manuals are updated.
There is no mechanism provided in the reporting process to factor in DNR (Do Not
Resuscitate) patients. Any mortalities occurring to a DNR patient are not
recognized separately; therefore mortality ratios may be accurate for reporting
standards but overstated.
Given the current certification software, due to hospital volumes, it is not
feasible to perform encounter level audits and edits. To meet the state's
mandates to submit hospital Outpatient visits with specific procedures, Huguley
underwent a major program conversion to the HCFA 837 EDI electronic claim
format.
All known errors have been corrected to the best of our knowledge. Due to the
issues with discharges being merged between multiple quarters at THCIC, we chose
not to certify the data for this quarter. However, the quarterly data to the
best of our knowledge is accurate and complete given the above.

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PROVIDER: Liberty-Dayton Regional Medical Center
THCIC ID: 089001
 QUARTER: 3
    YEAR: 2012

Certified With Comments

amount incorrect, can't correct., therefore certified batch.

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PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The data reports for Quarter 3, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

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PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain

an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

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

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

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

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial

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

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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PROVIDER: Columbia Medical Center-McKinney
THCIC ID: 246000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The Physicians name and NPI numbers are valid.
The Patients Control number is valid.
The Patients Social Security numbers are valid.

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PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

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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.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

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===
PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

===
PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to analyze the data. Regarding the mandate to communicate the Certification

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

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

We recommend the Patient communicate with the Hospital and the Physician
regarding data.
Patient and physician preference contributes to the care rendered to the patient
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Patients and physicians consider many factors when making health care decisions
that are not available in administrative data. These include a patients
preference for life-sustaining treatments, functional status, and other factors.

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decision-making. Quality improvement is not new; it is an on-going commitment.

===
PROVIDER: Mother Frances Hospital
THCIC ID: 286000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Claims dated September 30, 2012 will be reported with Quarter 4 2012, due to
system conversion constraints.

===
PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to
analyze the data. Regarding the mandate to communicate the Certification
reports to physicians The State does not offer a secure mechanism for us to
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===
PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes
(CPT Codes). This is mandated by the federal government. The hospital complies
with the guidelines for assigning these diagnosis codes; however, this is often
driven by physician's subjective criteria for defining a diagnosis. For
example, while one physician may diagnose a patient with anemia when the
patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-9-CM / CPT data on each outpatient receiving surgical or
radiological services, but has limited the number of diagnoses and procedures to
the first 25 diagnoses codes and the first 25 procedure codes. As a result, the

data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

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

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

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

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

===
PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

If a medical record is unavailable for coding the encounter is not billed and is

not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD 9 CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect

premature and sick babies mixed in with the normal newborn data. Texas Health Cleburne recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

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

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

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

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

===
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Baylor Medical Center at BUMC OUTPATIENT DATA
THCIC ID: 331000
QUARTER: 3
YEAR: 2012

CERTIFIED WITH COMMENTS

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

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

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

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

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

==
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Cook Children's Medical Center has submitted and certified 3rd QUARTER
2013 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 2013.

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

The data structure allowed by THCIC erroneously assigns surgeons to surgical
procedures they did not perform. The data structure provided by THCIC
allows for one attending and one operating physician assignment. However,
patients frequently undergo multiple surgeries where different physicians
perform multiple procedures. Assigning all of those procedures to a single
'operating physician' will frequently attribute surgeries to the wrong
physician. THCIC chooses to only assign one surgeon to a patient encounter,
not to each procedure.

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

===
PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000
 QUARTER: 3
    YEAR: 2012

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: 2012

Certified With Comments

The Physicians Name and NPI Numbers are valid
The Patients Control Numbers are Valid.
The Patients Social Security Number is Valid

===
PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The Physicians name and NPI numbers are valid.
The Patients Control numbers are valid.
The Patients Social Security numbers are valid.

===
PROVIDER: Baylor All Saints Medical Center-Fort Worth

THCIC ID: 363000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Baylor Medical Center at ASFW OUTPATIENT DATA
THCIC ID: 363000
QUARTER: 3
YEAR: 2012

CERTIFIED WITH COMMENTS

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

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

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

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

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

===
PROVIDER: Little River Healthcare
THCIC ID: 369000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

This quarter data contained SEVERAL errors. This was due to a computer
conversion and problems the software vendor had pulling the correct information
in the correct format for System 13. Unfortunately, the 4th quarter has many of
the same issues. We are working to improve the data submitted.

===
PROVIDER: Medical Center-Lewisville
THCIC ID: 394000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The Physicians name and NPI numbers are valid.
The Patients Control numbers are valid.

the Patients Social Security numbers are valid.

==
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Due to an Epic conversion and subsequent remapping, PPO, Blue Cross, Champus,
HMO and VA admissions may appear in the Commercial category for this quarter.

JPS Health Network
Comments on THCIC Data Submission
For
3rd Quarter 2012

Introduction

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

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

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

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

==
PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format.   Then the state specifications require additional data

elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is over and above the actual
hospital billing process. Errors can occur due to this additional programming,
but the public should not conclude that billing data sent to our payers is
inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD 9 CM. This is mandated by the federal government. The hospital
complies with the guidelines for assigning these diagnosis codes, however, this
is often driven by physician's subjective criteria for defining a diagnosis.
For example, while one physician may diagnose a patient with anemia when the
patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-9-CM data on each patient but has limited the number of diagnoses
and procedures to the first 25 diagnoses codes and the first 25 procedure codes.
As a result, the data sent by us does meet state requirements but cannot reflect
all the codes an individual patient's record may have been assigned. This means
also that true total volumes may not be represented by the state's data file,
which therefore make percentage calculations inaccurate (i.e. mortality
percentages for any given diagnosis or procedure, percentage of patients in each
severity of illness category). It would be obvious; therefore, those sicker
patients (more diagnoses and procedures) are less accurately reflected by the
837 format. It then stands to reason that hospitals, which treat sicker
patients, are likewise less accurately reflected.

Length of Stay
The length of stay data element contained in the states certification file is
only three characters long. Thus any patients discharged with a length of stay
greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is
not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate
whether the baby was a normal newborn, premature delivery, sick baby, extramural
birth, or information not available. The best way to focus on severity of

illness regarding an infant would be to check the infant's diagnosis at
discharge, not the admitting source code. Many hospital information systems and
registration process defaults to normal delivery as the admission source.
Therefore, admission source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal
neonates using the admit source to identify the cases, the data will reflect
premature and sick babies mixed in with the normal newborn data. Texas Health
Cleburne recommends use of ICD9 coding data to identify neonates. This
methodology will ensure correct identification of the clinical status of the
newborn admission.

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

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

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

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

===
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological services, by quarter year, gathered from a

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

Length of Stay
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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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==
PROVIDER: North Hills Hospital
THCIC ID: 437000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The Physicians name and NPI numbers are valid.
The Patients Control numbers are valid.
The Patients Social Security numbers are valid.

==
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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coded by the hospital using a universal standard called the International
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value. These values might not accurately reflect the hospital payer information,

because those payers identified contractually as both HMO, and PPO are
categorized as Commercial PPO. Thus any true managed care comparisons by
contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes
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: Seton Medical Center
THCIC ID: 497000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

==
PROVIDER: Medical Center-Arlington
THCIC ID: 502000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The Physicians name and NPI Numbers are valid, the Patient Control Numbers are
valid, and the Social Security Numbers are valid.

==
PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Seton Highland Lakes, a member of the Seton Family of hospitals, is a 25 bed
acute care facility located between Burnet and Marble Falls on Highway 281. The
hospital offers 24- hour Emergency services, plus comprehensive diagnostic and
treatment services for residents in the surrounding area. Seton Highland Lakes

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

===
PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

===
PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are

categorized as Commercial PPO. Thus any true managed care comparisons by
contract type (HMO vs. PPO) may result in inaccurate analysis.

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

==
PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Certified without edits data not reviewed due to employee turnover.
Submission, review & corrections will be completed for 4Q2012 data.

==
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often
driven by physician's subjective criteria for defining a diagnosis. For
example, while one physician may diagnose a patient with anemia when the
patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the

criteria used by the physician to determine that diagnosis was different.   An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes.   The hospital can code up to 99 diagnoses and 99 procedures for each patient record.   The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes.   As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

Length of Stay
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.
We received notification from THCIC indicating that there was an issue with the Outpatient Data reported for
2012. The THCIC Outpatient Technical Specifications Manual- Version 8 was updated on October 22, 2012 to include Revenue Code 0320, "Radiology, Diagnostic General Classification", which was unintentionally omitted when updating the THCIC Outpatient 837 5010 Technical Specifications Manual- Version 8. To correct this, THCIC required that all outpatient claims for 2012 be resubmitted to include the 0320 Revenue Code.

THR has been submitting this revenue code to the DFWHC with your outpatient data. To comply with the State's requirement. the DFWHC resubmitted all of the 1 Q and 2Q 2012 OP data. Since System13 had already built the 1 Q2012 Outpatient Certification data sets for 1 Q2012 claims submitted by August 1, the resubmitted claims were rolled into the 2Q2012 Outpatient Certification data set. which is causing the increase in your patient volume. The claims in the 1 Q2012 Certification data set that are duplicated in the 2Q2012 Certification data set. due to the resubmission of all 1 Q2012 data, will be removed by System 13 to prevent duplicate
1 Q2012 claims from the 2Q2012 certification data set, once the provider has completed the 2Q2012 certification.

This same process will occur with the 3Q2012 data.

==
PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Data Source - 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.

Charity Care This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burleson St. Joseph Health Center charity care, based on established rates for the first three quarters 2012was $761,462.

Patient Mix - All statistics for Burleson St. Joseph Health Center include patients from our Skilled Nursing, and Acute Care populations. Our Skilled Nursing unit is a long-term care unit. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Burleson St. Joseph Health Center and any "acute care only" facilities.

Physicians - All physician license numbers and names have been validated as accurate but some remain unidentified in the THCIC Practitioner Reference Files. Mortalities reported may be related to physicians other than the attending Physician. The attending physician is charged with the procedures requested or

performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patients age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patients diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

==
PROVIDER: Trinity Mother Frances Rehab Hospital
THCIC ID: 692000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

This hospital underwent conversion to the electronic health record in July 2012.
In the adoption process, data for July 2012 inadvertently was not submitted.

==
PROVIDER: Kindred Hospital Houston NW
THCIC ID: 706000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Certified without edits data not reviewed due to employee turnover.
Submission, review & corrections will be completed for 4Q2012 data.

==
PROVIDER: Kindred Hospital North Houston
THCIC ID: 713400
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Certified without edits data not reviewed due to employee turnover.
Submission, review & corrections will be completed for 4Q2012 data.

===
PROVIDER: Ennis Regional Medical Center
THCIC ID: 714500
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

===
PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often
driven by physician's subjective criteria for defining a diagnosis. For
example, while one physician may diagnose a patient with anemia when the
patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.

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

obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

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

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

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

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

==
PROVIDER: Methodist Willowbrook Hospital

THCIC ID: 724700
 QUARTER: 3
    YEAR: 2012

Certified With Comments

381 records errored out incorrectly and failed to be submitted

==
PROVIDER: Mother Frances Hospital-Jacksonville
THCIC ID: 725400
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Claims dated September 30, 2012 will be reported with Quarter 4 2012, due to
system conversion constraints.

==
PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Grimes St. Joseph Hospital uses TX 2400 format to do outpatient data submission
through its vendor Truven Health (http://truvenhealth.com/), formerly Thomson
Reuters.
Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. Grimes St. Joseph Hospital submits more
than required outpatient discharges to Thomson Reuters, who then converts the
submitted outpatient records to 837 format and sends all submitted outpatient
records to THCIC data warehouse System 13 Inc (https://thcic.system13.com).
Unwanted outpatient records, defined as those records containing non reportable
revenue codes, are dropped by System 13, Inc.

==
PROVIDER: Baylor Heart & Vascular Center
THCIC ID: 784400
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The IP Discharges total appears low I count 555. This report has 491. But the
distribution mix by charges, admission type, point of origin, discharge status,
DRGs, procedures, demographics, etc all appear reasonable.

The OP Discharges total appears low I count 4,668. This report has 3,714. But
the distribution mixes (as above) all appear reasonable.

==
PROVIDER: South Texas Spine & Surgical Hospital
THCIC ID: 786800
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Approved

===
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
  QUARTER: 3
     YEAR: 2012

Certified With Comments

To the best of my knowledge.

===
PROVIDER: Kindred Hospital Spring
THCIC ID: 792600
  QUARTER: 3
     YEAR: 2012

Certified With Comments

Certified without edits data not reviewed due to employee turnover.
Submission, review & corrections will be completed for 4Q2012 data.

===
PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
  QUARTER: 3
     YEAR: 2012

Certified With Comments

The data reports for Quarter 3, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

===
PROVIDER: Doctors Hospital-Renaissance
THCIC ID: 797100
  QUARTER: 3
     YEAR: 2012

Certified With Comments

Data was duplicated due to resubmission of outpatient claims for revenue code
0320 update.

==
PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

==
PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

==
PROVIDER: Kindred Hospital Tarrant County Fort Worth SW
THCIC ID: 800000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Certified without edits data not reviewed due to employee turnover.
Submission, review & corrections will be completed for 4Q2012 data.

==
PROVIDER: Lubbock Heart Hospital
THCIC ID: 801500
 QUARTER: 3
    YEAR: 2012

Elected Not to Certify

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

==
PROVIDER: Texas Health Harris Methodist Hospital Southlake

THCIC ID: 812800
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Files could have missing and duplicates

==
PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Files could have missing and duplicate claims

==
PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The Physicians name and NPI numbers are valid.
The Patients Control Numbers are valid.
The Patients Social Security Numbers are valid.

==
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

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

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

===
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Files could have missing or duplicate claims

===
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often
driven by physician's subjective criteria for defining a diagnosis. For
example, while one physician may diagnose a patient with anemia when the
patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.

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

The data submitted matches the state's reporting requirements but may be

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

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

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

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

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

===
PROVIDER: Good Shepherd Medical Center-Linden
THCIC ID: 822100
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

==
PROVIDER: Texoma Medical Center
THCIC ID: 847000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Data Source. The source of this data, the electronic bill, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.
*The billing data file limits the diagnosis codes to 25 (principal plus 24 secondary diagnosis codes); the admission diagnosis and up to nine E-code fields.
*The procedure codes are limited to 25 (principal plus 24 secondary).
*The fewer the codes the less information is available to evaluate the patients outcomes and service utilization
*The Hospital can only list 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

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

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

==
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Dell Children's Medical Center of Central Texas (DCMCCT) is the only children's hospital in the Central Texas Region. DCMCCT serves severely ill and/or injured children requiring intensive resources which increases the hospital's costs of care, lengths of stay and mortality rates. In addition, the hospital includes a Neonatal Intensive Care Unit (NICU) which serves very seriously ill infants, which substantially increases costs of care, lengths of stay and mortality rates.

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

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

===
PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Files could have missing or duplicate claims

===
PROVIDER: North Central Surgical Center
THCIC ID: 860600
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Included all imaging and surgical cases

===
PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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===
PROVIDER: TrustPoint Hospital
THCIC ID: 865800
 QUARTER: 3
    YEAR: 2012

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: 2012

Certified With Comments

The data reports for Quarter 3, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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are a snapshot of claims that have been billed prior to the reporting deadline.
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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: DeHaven Surgical Center
THCIC ID: 228002
 QUARTER: 3
    YEAR: 2012

Certified With Comments

certified on 10-26-12

==
PROVIDER: Heaton Laser & Surgery Center
THCIC ID: 377002
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Administrative update noted

==
PROVIDER: Platinum Surgery Center
THCIC ID: 380000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Some patients do not have SS#s

==
PROVIDER: ACPS Surgicentre
THCIC ID: 709100
 QUARTER: 3
     YEAR: 2012

Certified With Comments

One event for a Septoplasty shows incorrect dates of service.   Date of Service
8/13/2008 to 8/14/2013 should be 8/13/2013 to 8/14/2013.

==
PROVIDER: Plastic & Cosmetic Surgery Center of Texas
THCIC ID: 715500
 QUARTER: 3
     YEAR: 2012

Certified With Comments

There is a larger amount of claims on this quarter because 2012 Q2 was placed on
this quarter.
There was an error in submission on Q2 due to a computer update and claims had
been processed in "Test" mode. When finally aware it was too late and was later
submitted.

==
PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
 QUARTER: 3
     YEAR: 2012

Certified With Comments

As is.

==
PROVIDER: Outpatient Surgery Center
THCIC ID: 794500
 QUARTER: 3
     YEAR: 2012

Certified With Comments

3rd quarter

==
PROVIDER: Medical Village Surgery Center
THCIC ID: 804300
 QUARTER: 3
     YEAR: 2012

Certified With Comments

There is one case where the patient control number was entered in place of the
medical record number, and two cases where the procedure date was inadvertently
entered in lieu of the patients date of birth.

==

PROVIDER: Spine Team Texas ASC
THCIC ID: 816200
 QUARTER: 3
    YEAR: 2012

Certified With Comments

No Comments Necessary

==
PROVIDER: Spinecare
THCIC ID: 816900
 QUARTER: 3
    YEAR: 2012

Elected Not to Certify

DATA GENERATED FROM SCHEDULING SOFTWARE AND WE CANNOT CONFIRM 100% ACCURACY

==
PROVIDER: Memorial Hermann Surgery Center Woodlands
THCIC ID: 825400
 QUARTER: 3
    YEAR: 2012

Certified With Comments

No comments

==
PROVIDER: Dallas Endoscopy Center
THCIC ID: 826200
 QUARTER: 3
    YEAR: 2012

Certified With Comments

I SPOT CHECKED A FEW CLAIMS AND THEY LOOK GOOD.

==
PROVIDER: Texas Health Outpatient Surgery Center Stephenville
THCIC ID: 838800
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Data Content
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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.

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Race/Ethnicity
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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: 2012

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based
health centers and Parkland Memorial Hospital, which was established in 1894.
The Parkland System is a $995 million enterprise that is licensed for 968 beds
and employs approximately 9,071 staff. Approximately 1,599 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: The Center for Special Surgery at TCA
THCIC ID: 847800
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Good to go.

===
PROVIDER: Calloway Creek Surgery Center
THCIC ID: 859200
 QUARTER: 3
    YEAR: 2012

Certified With Comments

QTR 3 2012

==
PROVIDER: Spine Team Texas Rockwall ASC
THCIC ID: 902000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

No Comments Necessary

==
PROVIDER: Frisco Reproductive Surgery Center
THCIC ID: 903000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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

==
PROVIDER: Round Rock Surgery Center
THCIC ID: 905000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Previous Admin created and uploaded reports. Current Admin Certified.

==
PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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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: 2012

Certified With Comments

The data reports for Quarter 3, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

===
PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Files could have missing or duplicate claims

===
PROVIDER: Methodist Willowbrook Hospital Outpatient Surgery Department
THCIC ID: 862300
 QUARTER: 3
    YEAR: 2012

Certified With Comments

145 records erorred out incorrectly and failed to be submitted

===
PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Data Content
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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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Length of Stay

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Race/Ethnicity

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cost for performing the service.
Typically actual payments are much less than charges due to managed
care-negotiated discounts and denial of payment by insurance companies. Charges
also do not reflect the actual cost to deliver the care that each patient needs.

==
PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
 QUARTER: 3
    YEAR: 2012

Certified With Comments

The data reports for Quarter 3, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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quarter.

Severity

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

==
PROVIDER: JPS Surgical Center-Arlington
THCIC ID: 153300
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Due to an Epic conversion and subsequent remapping, PPO, Blue Cross, Champus,
HMO and VA admissions may appear in the Commercial category for this quarter.

JPS Health Network
Comments on THCIC Data Submission
For
3rd Quarter 2012

Introduction

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

Joint Commission accreditation as a hospital.

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

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

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

===
PROVIDER: HMU Surgical Center
THCIC ID: 194100
 QUARTER: 3
    YEAR: 2012

Certified With Comments

3rd Quarter Case Reconciliation Discrepancies
There were 8 Medicare cases entered and not included in certified data due to
non-reportable codes.
There were 2 Self-Pay cases not reported to state
There were 2 cases with a discrepancy in Surgeon
There is 1 case that has a DOS discrepancy

Under reporting was not intentional.

===
PROVIDER: Texas General Hospital
THCIC ID: 115100
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Certify without comments.

===
PROVIDER: Texas Health Harris Methodist Fort Worth Outpatient Surgery Center
THCIC ID: 970100
 QUARTER: 3
    YEAR: 2012

Certified With Comments

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because those payers identified contractually as both HMO, and PPO are
categorized as Commercial PPO. Thus any true managed care comparisons by
contract type (HMO vs. PPO) may result in inaccurate analysis.

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

Patient Volume
In the 3rd Quarter, 2012 report, there is no data reported for September, 2012.
The 3rd Quarter data had already been sent to Austin when the error was
identified so it cant be regenerated. The September data was resubmitted because
of the 320 rev code issue so the September data will be missing from the 3Q
publication, but the September data will be present in the 4Q data publication
and afterward. The data will be in the Q4 data set. Texas Health Harris
Methodist Hospital Fort Worth was not responsible for the omission.

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PROVIDER: Dodson Surgery Center
THCIC ID: 970400
 QUARTER: 3
    YEAR: 2012

Certified With Comments

Cook Children's Medical Center has submitted and certified 3rd QUARTER
2013 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 2013.

Patient charges that were accrued before admit or after discharge were
systematically excluded from the database. This can happen when a patient

is pre-admitted and incurs charges to their encounter before their admit
date or charges are discovered and added to the patient encounter after
they are discharged. Therefore, the charges for many patient encounters
are under reported.

The data structure allowed by THCIC erroneously assigns surgeons to surgical
procedures they did not perform. The data structure provided by THCIC
allows for one attending and one operating physician assignment. However,
patients frequently undergo multiple surgeries where different physicians
perform multiple procedures. Assigning all of those procedures to a single
'operating physician' will frequently attribute surgeries to the wrong
physician. THCIC chooses to only assign one surgeon to a patient encounter,
not to each procedure.

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

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PROVIDER: Huguley Surgery Center
THCIC ID: 971500
 QUARTER: 3
    YEAR: 2012

Elected Not to Certify

THCIC 3rd Quarter 2012 Huguley Memorial Medical Center Outpatient Comments
Elected not to Certify
Due to the notification from THCIC, October 29, 2012 the THCIC Outpatient
Technical Specification Manual was previously incorrect and specific revenue
codes were unintentionally omitted from the manual, the Huguley Memorial Medical
Center Outpatient dataset may have discharges included from a prior
Certification quarter. THCIC merged the missing patient encounters back into
the correct quarterly dataset. If the user of this dataset is able to filter
the 3rd quarter discharges from this dataset, the data should be accurate.
The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of June 1, 2013. If any
errors are discovered in our data after this point, we will be unable to
communicate these due to THCIC. This data is administrative data, which
hospitals collect for billing purposes, and not clinical data, from which you
can make judgments about patient care.
Submission Timing
The State requires us to submit a snapshot of billed claims, extracted from our
database approximately 20 days following the close of the calendar year quarter.
Any discharged patient encounters not billed by this cut-off date will not be
included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed which can alter the true picture of a patient's
hospitalization, sometimes significantly.
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using ICD-9-CM and CPT. This is mandated by the federal government and
all hospitals must comply.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code as many as 25
diagnoses and 25 procedures for each patient record. One limitation of using
the ICD-9-CM and CPT is that there does not exist a code for every possible

diagnosis and procedure due to the continued evolution of medicine; new codes
are added yearly as coding manuals are updated.
There is no mechanism provided in the reporting process to factor in DNR (Do Not
Resuscitate) patients. Any mortalities occurring to a DNR patient are not
recognized separately; therefore mortality ratios may be accurate for reporting
standards but overstated.

Given the current certification software, due to hospital volumes, it is not
feasible to perform encounter level audits and edits. To meet the state's
mandates to submit hospital Outpatient visits with specific procedures, Huguley
underwent a major program conversion to the HCFA 837 EDI electronic claim
format.
All known errors have been corrected to the best of our knowledge. Due to the
issues with discharges being merged between multiple quarters at THCIC, we chose
not to certify the data for this quarter. However, the quarterly data to the
best of our knowledge is accurate and complete given the above.

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PROVIDER: Pain Management Professionals of Baytown
THCIC ID: 972100
 QUARTER: 3
    YEAR: 2012

Certified With Comments

To my knowledge all claims entered are correct.