General Comments on 4th Quarter 2011 Data

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

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

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

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

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

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

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PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 4
YEAR: 2011

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 9,532 staff. 83,325 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: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
QUARTER: 4
YEAR: 2011

Certified With Comments

Due to the sheer volume of OP data, we have limited resources as a hospital to analyze the data. Regarding the mandate to communicate the Certification reports to physicians The State does not offer a secure mechanism for us to

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

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

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

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

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

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PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Madison St Joseph Health Center
THCIC ID: 041000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Baylor Medical Center at Carrollton

THCIC ID: 042000
 QUARTER: 4
    YEAR: 2011

Certified With Comments

Baylor Medical Center Carrollton OUTPATIENT DATA
THCIC ID: 042000
QUARTER: 4
YEAR: 2011

CERTIFIED WITH COMMENTS

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

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

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

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

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PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
 QUARTER: 4
    YEAR: 2011

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of August 30, 2012. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgments about patient care.
Submission Timing
The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all

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

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PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
QUARTER: 4
YEAR: 2011

Certified With Comments

The data reports for Quarter 4, 2011 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

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PROVIDER: University Medical Center
THCIC ID: 145000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Medical Center Hospital
THCIC ID: 181000
QUARTER: 4
YEAR: 2011

Certified With Comments

HCPCS are missing on the line item, will be corrected 1Q 2012.

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
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race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data

required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

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PROVIDER: Medical Center-Plano
THCIC ID: 214000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Hill Country Memorial Hospital
THCIC ID: 219000
QUARTER: 4
YEAR: 2011

Certified With Comments

Certifying claims with known errors. Working to fix claim errors in future files

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
QUARTER: 4
YEAR: 2011

Certified With Comments

Data Content
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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.
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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
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Length of Stay
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certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
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race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
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Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
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These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any 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-Stephenville
THCIC ID: 256000
QUARTER: 4
YEAR: 2011

Certified With Comments

Data Content
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accurately represent the clinical details of an encounter.
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services, by quarter year, gathered from a form called an UB92, in a standard government format called
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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
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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
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physician performance.
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is not always possible to determine if the patient had an infection prior to admission, or developed an
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such as complication rates.
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comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
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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: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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

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PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Texas Health Presbyterian Hospital - WNJ
THCIC ID: 297000
QUARTER: 4
YEAR: 2011

Certified With Comments

THCIC is not taking into consideration the way hospitals bill out patient data. All payors are allowing the billing of claims to be submitted this way without a claim(s) rejecting. The edit that THCIC has implemented isnt working correctly. Also, the THCIC reference tables need to be updated with correct versions.

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PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
QUARTER: 4
YEAR: 2011

Certified With Comments

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PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 4
YEAR: 2011

Certified With Comments

Data Content
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services, by quarter year, gathered from a form called an UB92, in a standard government format called
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since it is over and above the actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our payers is inaccurate. These
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universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to

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

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

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
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such as complication rates.
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Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

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PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 4
YEAR: 2011

Certified With Comments

Baylor Medical Center at BUMC OUTPATIENT DATA
THCIC ID: 331000
QUARTER: 4
YEAR: 2011

CERTIFIED WITH COMMENTS

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

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

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

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

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

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PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 4
YEAR: 2011

Certified With Comments

Cook Children's Medical Center has submitted and certified 4th QUARTER 2011 inpatient, outpatient surgery and outpatient radiology encounters to the Texas Health Care Information Council with the following possible data concerns based on the required submission method.

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

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

Comparative complication reports reflecting the above conditions could misstate the true conditions at Cook Children's Medical Center for the 4th QUARTER OF 2011.

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

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

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

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PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000
QUARTER: 4
YEAR: 2011

Certified With Comments

Subject: UMCB Comments

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

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

As the Regional Trauma Center, UMCB serves severely injured patients.

Lengths of stay and mortality rates are most appropriately compared to other trauma centers.

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

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

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PROVIDER: Denton Regional Medical Center
THCIC ID: 336001
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 4
YEAR: 2011

Certified With Comments

Baylor Medical Center at ASFW OUTPATIENT DATA
THCIC ID: 363000
QUARTER: 4
YEAR: 2011

CERTIFIED WITH COMMENTS

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

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

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

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

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

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PROVIDER: Baylor Medical Center-Southwest Fort Worth
THCIC ID: 363001
QUARTER: 4
YEAR: 2011

Certified With Comments

Baylor Medical Center at SWFW OUTPATIENT DATA
THCIC ID: 363001
QUARTER: 4
YEAR: 2011

CERTIFIED WITH COMMENTS

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

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

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

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

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

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PROVIDER: Medical Center-Lewisville
THCIC ID: 394000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Rollins Brooks Community Hospital
THCIC ID: 397000
QUARTER: 4
YEAR: 2011

Certified With Comments

Some encounters may be duplicated with a leading 0 on the medical record number. The duplication was not recognized by the computer and it was too late to complete a resubmission.

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PROVIDER: Metroplex Hospital
THCIC ID: 397001
QUARTER: 4
YEAR: 2011

Certified With Comments

Some encounters may be duplicated with a leading 0 in the medical record number - This duplication was not recognized by the computer and regenerattion was not requested in time for a resubmission.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 4
YEAR: 2011

Certified With Comments

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.

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing

race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 4
YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard government format called
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included over and above that. Adding those additional data places programming burdens on the hospital
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Diagnosis and Procedures
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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
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assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
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purposes. The hospital can code up to 99 diagnoses and 99 procedures for each

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but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
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Length of Stay
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any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
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Race/Ethnicity
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PROVIDER: North Hills Hospital
THCIC ID: 437000
 QUARTER: 4
    YEAR: 2011

Certified With Comments

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

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PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
QUARTER: 4
YEAR: 2011

Certified With Comments

The DeTar Healthcare System includes two full-service acute care hospitals: DeTar Hospital Navarro located at 506 E. San Antonio Street and DeTar Hospital North located at 101 Medical Drive. Both acute care hospitals are in Victoria, Texas. DeTar Healthcare System is both Joint Commission accredited and Medicare certified. The system also includes a Skilled Nursing Unit; two Emergency Departments with Level III Trauma Designation at DeTar Hospital Navarro and Level IV Trauma Designation at DeTar Hospital North; DeTar Health Center; a comprehensive Cardiology Program including Cardiothoracic Surgery; Accredited Chest Pain Center; Inpatient and Outpatient Rehabilitation Centers; an inpatient Geriatric Mental Health Center; the DeTar SeniorCare Center; Senior Circle; Primary Stroke Center; and a free Physician Referral Call Center. To learn more, please visit our website at www.detar.com.

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PROVIDER: DeTar Hospital-North
THCIC ID: 453001
QUARTER: 4
YEAR: 2011

Certified With Comments

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PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========
PROVIDER: Plaza Medical Center-Fort Worth
THCIC ID: 477000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========
PROVIDER: Seton Medical Center
THCIC ID: 497000
QUARTER: 4
YEAR: 2011

Certified With Comments

Subject: SMCA Comments

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

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

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

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PROVIDER: Medical Center-Arlington
THCIC ID: 502000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========

PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
QUARTER: 4
YEAR: 2011

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.

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PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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

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

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
QUARTER: 4
YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard government format called
HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be
included over and above that. Adding those additional data places programming burdens on the hospital
since it is over and above the actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our payers is inaccurate. These
errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data
submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly

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

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

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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

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

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PROVIDER: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
QUARTER: 4
YEAR: 2011

Certified With Comments

Results may not be 100% accurate.

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PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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PROVIDER: Surgery Specialty Hospitals of America-Southeast Houston
THCIC ID: 694100
QUARTER: 4
YEAR: 2011

Certified With Comments

*Comment contained confidential information and was removed by THCIC

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PROVIDER: CHRISTUS St Catherine Hospital
THCIC ID: 715901
QUARTER: 4

YEAR: 2011

Certified With Comments

Some of the claims that required corrections involving the physicians NPI number were are already correct but were coming up as incorrect. I took out the numbered and reentered but was still showing up as incorrect.

==========

PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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

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

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PROVIDER: Methodist Willowbrook Hospital
THCIC ID: 724700
QUARTER: 4
YEAR: 2011

Certified With Comments

The 2011 Q4 data is understated by 294 cases which errored out incorrectly and failed to be submitted.

==========

PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========

PROVIDER: Green Oaks Hospital
THCIC ID: 766000
QUARTER: 4
YEAR: 2011

Certified With Comments

Prior to October 2011, state reporting data was submitted to DFWHC and THCIC based upon final billed claims. Therefore, data submitted for 4th quarter 2011, accurately reflects the number of outpatients with reportable Revenue Codes including Revenue Code 752, but excluding non-reportable Revenue Code 459.

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PROVIDER: Baylor Medical Center-Frisco
THCIC ID: 787400
QUARTER: 4
YEAR: 2011

Certified With Comments

We continue to work with our EMR vendor to correct reporting requirements.

==========
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
QUARTER: 4
YEAR: 2011

Certified With Comments

Certified to the best of my knowledge.

==========
PROVIDER: LifeCare Hospital-Plano
THCIC ID: 789800
QUARTER: 4
YEAR: 2011

Certified With Comments

Unable to replicate all data elements.

==========
PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
QUARTER: 4
YEAR: 2011

Certified With Comments

The data reports for Quarter 4, 2011 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

==========
PROVIDER: Lubbock Heart Hospital
THCIC ID: 801500
QUARTER: 4
YEAR: 2011

Elected Not to Certify

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

==========
PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
QUARTER: 4
YEAR: 2011

Certified With Comments

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

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

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

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

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

==========
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 4
YEAR: 2011

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit outpatient claims for patients that receive outpatient surgical or radiological
services, by quarter year, gathered from a form called an UB92, in a standard government format called
HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be

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

accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
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race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Admit Type
In December 2011, Texas Health Presbyterian Hospital Denton transitioned to a new Electronic Health
Record (EHR). With this transition, there were issues with the data relating to Hispanic Ethnicity and
admission type (emergent vs. urgent) for multiple cases. A workflow change also has been identified that
affected the data for severity index. These issues could not be corrected before the data was submitted.
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: 4
YEAR: 2011

Certified With Comments

This data is submitted in an effort to meet statutory requirements. Conclusions drawn could be erroneous due to communication difficulties in reporting complete

data
caused by reporting constraints, subjectivity in assignment of codes, various system mapping and normal clerical error. Data submission deadlines prevent inclusion of
all applicable cases therefore this represents administrative claims data at the time of preset deadlines. Diagnostic and procedural data may be incomplete due to data
field limitations. Data should be cautiously used to evaluate health care quality and compare outcomes.

==========
PROVIDER: Methodist Sugar Land Hospital
THCIC ID: 823000
QUARTER: 4
YEAR: 2011

Certified With Comments

Data is certified. There were 311 events that errored out

==========
PROVIDER: Beaumont Bone & Joint Institute
THCIC ID: 826500
QUARTER: 4
YEAR: 2011

Certified With Comments

Error caused some 4q2011 claims to be submitted late and iafter discussing with system13 help desk they are included in 1q2012 claims.

==========
PROVIDER: St Joseph Medical Center
THCIC ID: 838600
QUARTER: 4
YEAR: 2011

Certified With Comments

St. Joseph Medical Center certified the outpatient data.

During this time period St. Joseph Medical Center provided charity care 140 patients with total charges (-$470,506.44) dollars. The system didn't identifty these patients.

==========
PROVIDER: University General Hospital
THCIC ID: 840200
QUARTER: 4
YEAR: 2011

Certified With Comments

Certified

==========
PROVIDER: Texoma Medical Center

THCIC ID: 847000
QUARTER: 4
YEAR: 2011

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 patient's outcomes and service utilization.
* The Hospital can only list 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

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

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

==========

PROVIDER: TrustPoint Hospital
THCIC ID: 865800
QUARTER: 4
YEAR: 2011

Elected Not to Certify

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

==========

PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
QUARTER: 4
YEAR: 2011

Certified With Comments

The data reports for Quarter 4, 2011 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

==========

PROVIDER: DeHaven Surgical Center
THCIC ID: 228002
QUARTER: 4
YEAR: 2011

Certified With Comments

certified on 0717 lpm

==========

PROVIDER: Platinum Surgery Center
THCIC ID: 380000
QUARTER: 4
YEAR: 2011

Certified With Comments

Sorry batch was sent doubled

==========

PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
QUARTER: 4
YEAR: 2011

Certified With Comments

AS IS.

==========

PROVIDER: Texas Orthopedics Surgery Center
THCIC ID: 784600
QUARTER: 4
YEAR: 2011

Certified With Comments

ok per Yvonne

==========

PROVIDER: SurgEyeCare General Partnership
THCIC ID: 786100

QUARTER: 4
YEAR: 2011

Certified With Comments

This batch submitted by billing company and should have been certified by billing company
CK

==========
PROVIDER: Caplan Surgery Center
THCIC ID: 796001
QUARTER: 4
YEAR: 2011

Certified With Comments

re opened certification to add October surgeries. Added 4/18/12. recertified

==========
PROVIDER: Medical Village Surgery Center
THCIC ID: 804300
QUARTER: 4
YEAR: 2011

Certified With Comments

There were three instances where the procedure date was inadvertently entered in lieu of the patients date of birth, and two instances where no diagnosis was entered in for the reason for visit.

==========
PROVIDER: Physicians Surgery Center Longview
THCIC ID: 806400
QUARTER: 4
YEAR: 2011

Certified With Comments

Elect to certify for the month of October, 2011 but not to certify for November and December, 2011 due to a computer conversion that inadequantly stored and processed our data.

==========
PROVIDER: Sonterra Endoscopy Center
THCIC ID: 806900
QUARTER: 4
YEAR: 2011

Certified With Comments

Was unable to correct errors due to the fact I was in hospital for surgery and out on sick leave for 6 weeks.

==========
PROVIDER: Headache & Pain Ambulatory Surgery Center
THCIC ID: 809900
QUARTER: 4

YEAR: 2011

Certified With Comments

Frequency of Errors Report (Outpatient- Professional)
This report indicates that there was an error because no patient social security number was entered on four claims.

No social security number was entered because those patients do not have a social security number assigned to them.

==========
PROVIDER: Foundation West Houston Surgical Center
THCIC ID: 810500
QUARTER: 4
YEAR: 2011

Certified With Comments

the data has been reviewed to the best of our ability, certified for Chris Riedel R.N administrator by ann elahi bom

==========
PROVIDER: Spine Team Texas ASC
THCIC ID: 816200
QUARTER: 4
YEAR: 2011

Certified With Comments

No Comments

==========
PROVIDER: Spinecare
THCIC ID: 816900
QUARTER: 4
YEAR: 2011

Elected Not to Certify

ELECT NOT TO CERTIFY

==========
PROVIDER: Texas Endoscopy
THCIC ID: 818400
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========
PROVIDER: Memorial Hermann Surgery Center Woodlands
THCIC ID: 825400
QUARTER: 4
YEAR: 2011

Certified With Comments

No comments

==========
PROVIDER: Dallas Endoscopy Center
THCIC ID: 826200
 QUARTER: 4
    YEAR: 2011

Certified With Comments

after spot checking several claims everything looks to be correct.

==========
PROVIDER: Doctors Surgery Center at Huguley
THCIC ID: 831600
 QUARTER: 4
    YEAR: 2011

Certified With Comments

Certified by Becky Hernandez

==========
PROVIDER: Brazoria County Surgery Center
THCIC ID: 835900
 QUARTER: 4
    YEAR: 2011

Certified With Comments

subject to IT vendor issues resolved with system 13 direct

==========
PROVIDER: Texas Health Outpatient Surgery Center Stephenville
THCIC ID: 838800
 QUARTER: 4
    YEAR: 2011

Certified With Comments

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

errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data
submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a
universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective
criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when
the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with
anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly
assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to
apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or
physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the
hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it
is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things
such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on
the number of diagnoses and procedures the state allows us to include for each patient. In other words, the
state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing
purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state
is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services,
but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the
codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus
any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that
this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be

creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not
routinely collect race and ethnicity as part of the admission process, that this has been added to meet the
THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing
08/06/12
4
race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race
and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an
accurate representation of the patient population for a facility.
Admit Type
In December 2011, the Texas Health Outpatient Surgery Center identified a difference seen between service and
revenue centers. The cause for the difference has been identified and a plan is in place to crorrect it.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that
is not contained within the standard UB92 billing record. In order to meet this requirement, each payer
identifier must be categorized into the appropriate standard and non-standard source of payment value.
These values might not accurately reflect the hospital payer information, because those payers identified
contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care
comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that
charges are not equal to actual payments received by the hospital or hospital cost for performing the service.
Typically actual payments are much less than charges due to managed care-negotiated discounts and denial
of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each
patient needs.

==========
PROVIDER: Simmons Ambulatory Surgery Center
THCIC ID: 843300
 QUARTER: 4
    YEAR: 2011

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 9,532 staff. Approximately 1,620 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: Calloway Creek Surgery Center
THCIC ID: 859200
QUARTER: 4
YEAR: 2011

Certified With Comments

I was not the one who prepared this report so if there are any problems please call me at 817-548-4000, Marie Fear

==========
PROVIDER: Spine Team Texas Rockwall ASC
THCIC ID: 902000
QUARTER: 4
YEAR: 2011

Certified With Comments

No comments necessary.

==========
PROVIDER: HEA Surgery Center
THCIC ID: 906000
QUARTER: 4
YEAR: 2011

Certified With Comments

Certified by Julie Gallaher and Diana Delafuente

==========
PROVIDER: CHRISTUS Santa Rosa Physicians Ambulatory Surgery Center
THCIC ID: 917000
QUARTER: 4
YEAR: 2011

Certified With Comments

100% 4th q. Great!

==========
PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
QUARTER: 4
YEAR: 2011

Certified With Comments

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but

some remain unidentified in the THCIC Practitioner Reference Files.

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

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PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 4
YEAR: 2011

Certified With Comments

The data reports for Quarter 4, 2011 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

==========

PROVIDER: Texas Endoscopy
THCIC ID: 818401
QUARTER: 4
YEAR: 2011

Certified With Comments

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

==========

PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
QUARTER: 4
YEAR: 2011

Certified With Comments

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

hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International Classification of Disease (ICD-9-CM) and Current Procedural Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes; however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an
infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM / CPT data on each outpatient receiving surgical or radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.
Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by
hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment

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

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PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
QUARTER: 4
YEAR: 2011

Certified With Comments

The data reports for Quarter 4, 2011 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

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PROVIDER: JPS Surgical Center-Arlington
THCIC ID: 153300
QUARTER: 4
YEAR: 2011

Certified With Comments

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.