General Comments on 2nd Quarter 2021 Data
The following general comments about the data for this quarter are made by THCIC
and apply to all data released for this quarter.
· Data are administrative data, collected for billing purposes, not
clinical data.
· Data are submitted in a standard government format, the 837 format
used for submitting billing data to payers. State specifications require
the submission of additional data elements. These data elements include
race and ethnicity. Because these data elements are not sent to payers and may
not be part of the hospital's standard data collection process, there may be an
increase in the error rate for these elements. Data users should not conclude
that billing data sent to payers is inaccurate.
· Hospitals are required to submit the patient's race and ethnicity
following categories used by the U. S. Bureau of the Census. This information
may be collected subjectively and may not be accurate.
· Hospitals are required to submit data within 60 days after the close of
a calendar quarter (hospital data submission vendor deadlines may be sooner).
Depending on hospitals' collection and billing cycles, not all discharges may
have been billed or reported. Therefore, data for each quarter may not be
complete. This can affect the accuracy of source of payment data, particularly
self-pay and charity categories, where patients may later qualify
for Medicaid or other payment sources.
· Conclusions drawn from the data are subject to errors caused by the
inability of the hospital to communicate complete data due to reporting form
constraints, subjectivity in the assignment of codes, system mapping, and normal
clerical error. The data are submitted by hospitals as their best effort to meet
statutory requirements.

===
PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

This data is submitted in an effort to meet statutory requirements. It is
administrative data not clinical data and is utilized for billing and planning
purposes. Conclusions drawn could be erroneous due to reporting constraints,
subjectivity in assignments of codes, system mapping and normal clerical error.
Diagnostic and procedural data may be incomplete due to data field limitations
or circumstances outside of daily operations. Race and ethnicity may be
subjectively collected and may not provide an accurate representation of the
patient population for a facility. It should also be noted that charges are not
equal to actual payments received by the facility or facility costs for
performing the service

===
PROVIDER: CHRISTUS Good Shepherd Medical Center-Marshall

THCIC ID: 020000
 QUARTER: 2
    YEAR: 2021

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: CHRISTUS Good Shepherd Medical Center-Longview
THCIC ID: 029000
 QUARTER: 2
    YEAR: 2021

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: United Memorial Medical Center
THCIC ID: 030000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Syed

===
PROVIDER: St Davids Hospital
THCIC ID: 035000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
All errors have been reviewed and corrected to the best of the facilities
ability.

==
PROVIDER: Baylor Scott & White Medical Center Taylor
THCIC ID: 044000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Taylor
THCIC ID 044000
2nd Qtr 2021 – Inpatient
Accuracy rate – 100%
No comments needed.

==
PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of January 13, 2022. If any
errors are discovered in our data after this point, we will be unable to
communicate these due to THCIC rules. This data is administrative data, which
hospitals collect for billing purposes, and not clinical data, from which you
can make judgments about patient care.
Submission Timing
To meet the States submission deadline, approximately 30 days following the
close of the calendar year quarter, we submit a snapshot of billed claims,
extracted from our database. Any discharged patient encounters no billed by
this cut-off date will not be included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed which can alter the true picture of a patient's

hospitalization, sometimes significantly.
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a ICD-10-CM effective 10-1-2015. This is mandated by the federal government and all hospitals must comply.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-10-CM is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.
There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore, mortality ratios may be accurate for reporting standards but overstated.
Physician
While the hospital documents many treating physicians for each case, the THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians. Many physicians provide care to patients throughout a hospital stay. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Analysis of "Other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.
In our continuous efforts to monitor our data for accuracy we have found some disparity with our ethnicity volume compared to a population sampling. To correct reporting the patient access team has undergone additional education to ensure fields are appropriately identified at all points of registration.
Due to hospital volumes, it is not feasible to perform encounter level audits and edits. All known errors have been corrected to the best of our knowledge.
Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

==
PROVIDER: Baylor Scott & White Hospital-Brenham
THCIC ID: 066000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Hospital-Brenham
THCIC ID 066000
2nd Qtr 2021 Inpatient
Accuracy rate – 99.73%
Errors from the 2nd Quarter FER reflect the following error code E-618.
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

```
================================================================================
PROVIDER: CHI St Lukes Health Memorial San Augustine
THCIC ID: 072000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Certifier is I.T. and not Local Facility.


================================================================================
PROVIDER: Wilbarger General Hospital
THCIC ID: 084000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Reviewed and saved


================================================================================
PROVIDER: Hunt Regional Medical Center Greenville
THCIC ID: 085000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Greenville - 08500 - E-618 - Patient was presented as OP, had subsequent surgery
and required inpatient care postoperatively.


================================================================================
PROVIDER: Montgomery County Mental Health Treatment Facility
THCIC ID: 100087
 QUARTER: 2
    YEAR: 2021

Certified With Comments

One claim in April reported 3rd Quarter bringing total 50 Encounters to 49
Encounters for 2nd Quarter 2021


================================================================================
PROVIDER: TMC Bonham Hospital
THCIC ID: 106001
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  QUARTER: 2
     YEAR: 2021


Certified With Comments


Certified as accurate



================================================================================
PROVIDER: Baptist Medical Center
THCIC ID: 114001
 QUARTER: 2
     YEAR: 2021


Certified With Comments


I (Removed by THCIC) certify on behalf of (Removed by THCIC)


*Potential confidential information removed by THCIC.
================================================================================
PROVIDER: CHI St Lukes Health Memorial Lufkin
THCIC ID: 129000
 QUARTER: 2
     YEAR: 2021


Certified With Comments


Certifier is National I.T. and Not Local Facility.



================================================================================
PROVIDER: The Hospitals of Providence Memorial Campus
THCIC ID: 130000
 QUARTER: 2
     YEAR: 2021


Certified With Comments


No comments required



================================================================================
PROVIDER: Northeast Baptist Hospital
THCIC ID: 134001
 QUARTER: 2
     YEAR: 2021


Certified With Comments


A: Type of Data Errors:
```

From Patient Access Director - claim corrections for Patient Access are
resulting from SS#.
From Coding Dept.: I have reviewed the IP accounts, 6 accounts needed a
corrected SS#. I reviewed the medical record and the address submitted on the
claim matches the address in the medical record.
B: Why corrects were not completed:
We had leadership on FMLA and leadership change leading to not have access to
this system at all at this time.
I hereby certify on behalf of (Removed by THCIC), CFO at Northeast Baptist
Hospital. (Removed by THCIC), Director Revenue Analysis at Northeast Baptist
Hospital.

*Potential confidential information removed by THCIC.
==
PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data represents information at the time of submission. Subsequent changes may
continue to occur which will not be reflected in this published dataset. UMC
works continually to minimize and rectify errors in our public reporting.

==
PROVIDER: Methodist Hospital
THCIC ID: 154000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
W-696 Invalid Operating Practitioner Name Match: NPI name match corrected, error
may be due to double name or hyphenated name
All errors have been reviewed and corrected to the best of the facilities
ability.

==
PROVIDER: Methodist Specialty & Transplant Hospital
THCIC ID: 154001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
E- 617 - Other Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and mock billing
practices
All errors have been reviewed and corrected to the best of the facilities
ability

==
PROVIDER: Northeast Methodist Hospital
THCIC ID: 154002
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
All errors have been reviewed and corrected to the best of the facilities
ability.

==
PROVIDER: Methodist Texsan Hospital
THCIC ID: 154003
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
E- 617 - Other Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and mock billing
practices
All errors have been reviewed and corrected to the best of the facilities
ability.

==
PROVIDER: Guadalupe Regional Medical Center
THCIC ID: 155000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data is being certified at less than 100% due to a processing error. A guide
was produced to avoid future errors.

===
PROVIDER: Las Palmas Medical Center
THCIC ID: 180000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

This data is submitted in an effort to meet statutory requirements. It is
administrative data not clinical data and is utilized for billing and
administrative decisions at a facility level and transparency with state
entities. Conclusions drawn could be erroneous due to reporting constraints,
subjectivity in assignment of codes, system mapping and normal clerical error.
It should be noted that charges are not equal to actual payments received by the
facility or facility costs for performing the services. Most errors occurring
are due to incorrect country codes utilized on patients with addresses in Mexico
for this reporting timeline. These were corrected to the bandwidth of the
resources available. There are additional resources that will be utilized with
the coming quarters of data to decrease the error rate prior to certification.

===
PROVIDER: Medical Center Hospital
THCIC ID: 181000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Had one encounter with manifest diagnosis.

===
PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

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

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

Diagnosis and Procedures

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

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

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

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

patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some

patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==
PROVIDER: Baylor Scott & White Hospital College Station
THCIC ID: 206100
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Hospital College Station
THCIC ID 206100
2nd Qtr 2021 Inpatient
Accuracy rate - 99.95%
Errors from the 2nd Quarter FER reflect the following error code E-618.
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

==
PROVIDER: Laredo Medical Center
THCIC ID: 207001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Errors due to incorrect Social Securities.
Few claims not coded yet.
No information for Admitting provider.

==
PROVIDER: Baylor Scott & White The Heart Hospital Denton
THCIC ID: 208100
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White The Heart Hospital Denton
THCIC ID 208100
2nd Qtr 2021 Inpatient
Accuracy rate –- 100%
No comments needed.

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================================================================================
PROVIDER: CHRISTUS Spohn Hospital-Kleberg
THCIC ID: 216001
 QUARTER: 2
    YEAR: 2021
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Certified With Comments

Certify gmr

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================================================================================
PROVIDER: HCA Houston Healthcare Northwest
THCIC ID: 229000
 QUARTER: 2
    YEAR: 2021
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Certified With Comments

All errors were corrected to best of our ability.

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================================================================================
PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
 QUARTER: 2
    YEAR: 2021
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Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The

hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An 'apples to apples' comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal

neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Allen recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record.   In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both 'HMO, and PPO' are categorized as 'Commercial PPO'. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically, actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==
PROVIDER: Medical City-McKinney
THCIC ID: 246000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

INFORMATION IS VALID

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PROVIDER: Wise Health System-Medical Center
THCIC ID: 254001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

These records are correct and current as of the day that they were submitted
and/or corrected. Any missing or incorrect information is due to information
that was not available.


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================================================================================
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PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
'apples to apples' comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely

collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==
PROVIDER: Plains Memorial Hospital
THCIC ID: 260000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

We did not have any Inpatients for the the month of JUNE, we only had Observation and Swing Beds

==
PROVIDER: University Medical Center of El Paso-Alameda
THCIC ID: 263000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

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

==
PROVIDER: The Hospitals of Providence Sierra Campus
THCIC ID: 266000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No comments required.

==
PROVIDER: Swisher Memorial Hospital
THCIC ID: 273000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

My Inpatient data for 2Q2021 is at 92% accuracy rate. I got behind and missed the deadline to correct these claims. I am sorry. There were 2 claims that needed to be corrected and they were not. These errors included incorrect or missing Primary Payer Source Codes/Payer Names along with 2 other diagnosis codes. These claims are usually Self Pay or Indigent claims that are just missing the Payer Name.

==
PROVIDER: Baylor Scott & White Medical Center Waxahachie
THCIC ID: 285000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Waxahachie
THCIC ID 285000
2nd Qtr 2021 – Inpatient
Accuracy rate – 99.90%

Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==
PROVIDER: Wilson N Jones Regional Medical Center
THCIC ID: 297000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

some error are due to manual entry.

==
PROVIDER: Baylor Scott & White Medical Center-Irving
THCIC ID: 300000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center-Irving
THCIC ID 300000
2nd Qtr 2021 Inpatient
Accuracy rate – 99.89%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618,
and E-672
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Invalid service line procedure code verified, reported as posted.
Errors will stand "as reported".

==
PROVIDER: Doctors Hospital-Laredo
THCIC ID: 301000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Not at 100% due to duplicate accounts that were pending corrections at time of
correction deadline.

==

PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
'apples to apples' comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission or
developed an infection during their hospitalization. This makes it difficult to
obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

categorized as 'Commercial PPO'. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically, actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

===
PROVIDER: Del Sol Medical Center
THCIC ID: 319000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

===
PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
'apples to apples' comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission or
developed an infection during their hospitalization. This makes it difficult to
obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-10-CM data on each patient but has limited the number of diagnoses
and procedures to the first 25 diagnoses codes and the first 25 procedure codes.
As a result, the data sent by us does meet state requirements but cannot reflect
all the codes an individual patient's record may have been assigned. This means
also that true total volumes may not be represented by the state's data file,
which therefore make percentage calculations inaccurate (i.e. mortality

percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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

denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

===
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor University Medical Center
THCIC ID 331000
2nd Qtr 2021 Inpatient
Accuracy rate – 99.97%
Errors from the 2nd Quarter FER reflect the following error code E-618.
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

===
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Cook Children's Medical Center has submitted and certified SECOND QUARTER 2021 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 SECOND QUARTER OF 2021.
There may be some encounters will have one of the following issues:
Questionable Revenue Procedure Modifier 1
Questionable Revenue Procedure Modifier 2

These are errors that are very difficult, if not impossible to correct as that is how they are sent to the respective payers. This is especially true for modifier errors related to transport (Rev Codes 0540 & 0545). Per the following website, these modifiers appear to be legitimate: https://www.findacode.com/code-set.php?set=HCPCSMODA.
Additionally, there may be outpatient encounters where there is an invalid NPI associated with the attending provider. These are most likely to be encounters in the ED where a patient was seen by a nurse in triage and charges were incurred, but left without being seen by a physician or an advanced nurse provider.
However, our overall accuracy rate is very high, so this will be a small proportion of our encounters.
We will continue to work with the Revenue Cycle team to improve the accuracy of the data elements going forward.
This will affect encounters for the SECOND QUARTER OF 2021
Patient charges that were accrued before admit or after discharge were systematically excluded from the database. This can happen when a patient is pre-admitted and incurs charges to their encounter before their admit date or charges are discovered and added to the patient encounter after they are discharged. Therefore, the charges for many patient encounters are under reported.
The data structure allowed by THCIC erroneously assigns surgeons to surgical procedures they did not perform. The data structure provided by THCIC allows for one attending and one operating physician assignment. However, patients frequently undergo multiple surgeries where different physicians perform multiple procedures. Assigning all of those procedures to a single 'operating physician' will frequently attribute surgeries to the wrong physician. THCIC chooses to only assign one surgeon to a patient encounter, not to each procedure.
Furthermore, the data structure established by THCIC allows for a limited number of diagnoses and procedures. Patients with more than the limit for diagnoses or procedures will be missing information from the database. This is especially true in complex cases where a patient has multiple major illnesses and multiple surgeries over an extended stay.

==
PROVIDER: HCA Houston Healthcare West
THCIC ID: 337001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

There are no errors

==
PROVIDER: Medical Arts Hospital
THCIC ID: 341000

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 QUARTER: 2
    YEAR: 2021

Certified With Comments

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


===============================================================================
PROVIDER: Coryell Memorial Hospital
THCIC ID: 346000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Coryell Health metrics indicate 180 inpatient encounters for 2Q 2021.


===============================================================================
PROVIDER: Nocona General Hospital
THCIC ID: 348000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Being a small facility with limited nurses, doctors, etc, we were caught up in
the Pandemic with many staff out with COVID so documentation was not done timely
enough to report within the quarter you required.  47 encounters were the
completed ones but there were more encounters that were not ready until after
the deadline.


===============================================================================
PROVIDER: Baylor Scott & White All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White All Saints Medical Center-Fort Worth
THCIC ID 363000
2nd Qtr 2021 Inpatient
Accuracy rate – 99.98
Errors from the 2nd Quarter FER reflect the following error codes E-767.
Principal procedure date verified in hospital system , reported as posted
```

Errors will stand as reported.

```
================================================================================
PROVIDER: Martin County Hospital District
THCIC ID: 388000
 QUARTER: 2
    YEAR: 2021
```

Certified With Comments

I certify that this data is correct to the best of my knowledge on this date of certification.

```
================================================================================
PROVIDER: Nacogdoches Medical Center
THCIC ID: 392000
 QUARTER: 2
    YEAR: 2021
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Certified With Comments

report reviewed and certified

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================================================================================
PROVIDER: CHRISTUS Spohn Hospital Corpus Christi
THCIC ID: 398000
 QUARTER: 2
    YEAR: 2021
```

Certified With Comments

Certified gmr

```
================================================================================
PROVIDER: CHRISTUS Spohn Hospital Corpus Christi-Shoreline
THCIC ID: 398001
 QUARTER: 2
    YEAR: 2021
```

Certified With Comments

Certified gmr

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================================================================================
PROVIDER: CHRISTUS Spohn Hospital Corpus Christi-South
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THCIC ID: 398002
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Certified gmr

==
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

JPS Health Network
Comments on THCIC Data Submission
Introduction
John Peter Smith Hospital (JPSH) is operated by JPS Health Network
under the auspices of the Tarrant County Hospital District. The JPS Health
Network is accredited by the Joint Commission. In addition, JPSH holds
Joint Commission accreditation as a hospital.
JPSH is the only Texas Department of Health certified Level I Trauma
Center in Tarrant County and includes the only psychiatric emergency center in
the county. The hospital's services include intensive care for adults and
newborns, an AIDS treatment center, a full range of obstetrical and
gynecological services, adult inpatient care and an inpatient mental health
treatment facility.
JPSH is a major teaching hospital offering, or providing through co-operative
arrangements, postdoctoral training in orthopedics, obstetrics and gynecology,
psychiatry, surgery, oral and maxillofacial surgery, radiology, sports medicine,
podiatry and pharmacy. The family medicine residency is the largest
hospital-based family medicine residency program in the nation.
In addition to JPSH, the JPS Health Network operates community health
centers located in medically underserved areas of Tarrant County; school-based
health clinics; outpatient programs for pregnant women, behavioral health and
cancer patients; and a wide range of wellness education programs.
JPSH has confirmed that for errors related to "Other Procedure Date must be on
or after the 3rd day before the Admission Date", patient was in observation
status at the time of the procedure. Procedure date and time are accurate based
on when the procedure was completed.
After review of the required THCIC claim submission data criteria, JPSH has
amended their reporting criteria to include previously omitted closed accounts
and align with THCIC requirements. The change will impact reported data
starting 4th Quarter 2021 and may change overall reporting volume.

==

PROVIDER: Hereford Regional Medical Center
THCIC ID: 420000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

For Quarter 2 2021, we had a large number of corrections due to the submission
of the claims to the system. Alot of information is uploaded with incorrect
information. We have a lot of outpatient visits that are inpatient in our EHR
but is considered outpatient in the system so alot of information is left out.
We also have social security numbers incorrect, payer sources inaccurate and
some charges are wrong and need to be correct, all our worksmart claims are
pulled across and we need to correct or delete.
Our errors are:
Social Security
Worksmart claims
Inpatient that needs to be outpatient
Payor Sources
Demographics
Some charges
But all of the errors are the way it is uploaded in the system. The claims are
correct in our EHR.
The corrections were not completed due to a miscommunication here at the office.
Office staff believed it was complete and it was not. We will be training more
staff and will make sure and have them run a frequency of errors report before
certifing.

==
PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to 'newborn', the admit source should indicate

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==
PROVIDER: Ascension Seton Smithville
THCIC ID: 424500
 QUARTER: 2

YEAR: 2021

Certified With Comments

Ascension Seton Bastrop, a member of Ascension Texas, is a state of the art
hospital and medical office building located along highway 71 that services
residents of Bastrop and surrounding counties. The wide range of specialties and
services provided include: 24 hour emergency care, inpatient services, primary
care and family medicine, outpatient maternal fetal medicine, heart and vascular
care including vascular imaging services, cardiac rehabilitation, outpatient
neurosurgery care, outpatient respiratory services including pulmonary function
tests and arterial blood gas testing, womens diagnostics services including
mammography and dexa, and onsite imaging (CT, X-ray, ultrasound) and laboratory
services.
All physician license numbers and names have been validated with the Physician
and the Texas State Board of Medical Examiner website as accurate but some
remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory
requirements

==
PROVIDER: CHRISTUS Spohn Hospital-Beeville
THCIC ID: 429001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Done gmr

==
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

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

Race/Ethnicity

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Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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

Discharge Disposition

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

==

PROVIDER: UT Southwestern University Hospital-Clements University
THCIC ID: 448001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E-617 & E-618 Procedure dates are correct
E-665 SSN's could not be obtained 999999999 was entered

==
PROVIDER: UT Southwestern University Hospital-Clements Psych
THCIC ID: 448002
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No Errors

==
PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

For DeTar Hospital Navarro's Q2 2021 data submission, there were 1,447 inpatient
encounters with only 1 inpatient account with an error on a claim that included
more than one admission-thru-discharge claim that could not be corrected.

==
PROVIDER: CHI St Lukes Health - Memorial Livingston
THCIC ID: 466000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Certifier is I.T. and not Local Facility.

==
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 2

YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
'apples to apples' comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission or
developed an infection during their hospitalization. This makes it difficult to
obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-10-CM data on each patient but has limited the number of diagnoses
and procedures to the first 25 diagnoses codes and the first 25 procedure codes.

As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges.
It is important to note that charges are not equal to actual payments received
by the hospital or hospital cost for performing the service. Typically, actual
payments are much less than charges due to managed care-negotiated discounts and
denial of payment by insurance companies. Charges also do not reflect the actual
cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some
patient discharges to "home" as opposed to rehab. THR will communicate this
issue and the plan to address this issue in writing to the THCIC Executive
Director.

===
PROVIDER: Memorial Medical Center
THCIC ID: 487000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Accounts have been corrected to the best of our ability.

===
PROVIDER: Ascension Seton Medical Center
THCIC ID: 497000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Seton Medical Center Austin, a member of Ascension Texas, 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.
These data are submitted by the hospital as their best effort to meet statutory
requirements.
2021Q2 Inpatient submission accuracy = 99.48%
32 errors on 30 inpatient claims (representing only 0.52% of claims) were unable
to be corrected prior to certification. The primary resources with user
permissions that can technically resolve the data errors do not have the
expertise to resolve all errors; and in some cases the errors are not
resolvable. SSN errors (4) were due to incomplete or inaccurate information
entered; country errors (3) were due to missing information; and admission type

errors (5) were due to incorrect code mappings. For physician ID errors (18), all Physician license numbers and names have been validated by the Physician and the Texas State Board of Medical Examiners website, but some remain unidentified in the THCIC Practitioner Reference files.

==
PROVIDER: Medical City Arlington
THCIC ID: 502000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

INFORMATION IS VALID

==
PROVIDER: Baylor Scott & White Medical Center Hillcrest
THCIC ID: 506001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Hillcrest
THCIC ID 506001
2nd Qtr 2021 – Inpatient
Accuracy rate – 99.94%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==
PROVIDER: Baylor Scott & White Medical Center-Grapevine
THCIC ID: 513000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center-Grapevine
THCIC ID 513000
2nd Qtr 2021 Inpatient
Accuracy rate – 99.94%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted

Errors will stand as reported

==
PROVIDER: Baylor Scott & White Medical Center Temple
THCIC ID: 537000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Temple
THCIC ID 537000
2nd Qtr 2021 – Inpatient
Accuracy rate – 99.81%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

==
PROVIDER: Baylor Scott & White McLane Childrens Medical Center
THCIC ID: 537006
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White McLane Childrens Medical Center
THCIC ID 537006
2nd Qtr 2021 – Inpatient
Accuracy rate -100%
No comments needed.

==
PROVIDER: Ascension Seton Highland Lakes
THCIC ID: 559000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Ascension Seton Highland Lakes, a member of Ascension Texas, is a 25-bed acute
care facility designated as a Critical Access Hospital.
These data are submitted by the hospital as their best effort to meet statutory
requirements.
2021Q2 Inpatient submission accuracy = 99.26%
1 operating practitioner ID error on 1 inpatient claim (representing only 0.74%

of claims) was unable to be corrected prior to certification. The primary
resources with user permissions that can technically resolve the data errors do
not have the expertise to resolve all errors; and in some cases the errors are
not resolvable. All Physician license numbers and names have been validated by
the Physician and the Texas State Board of Medical Examiners website, but some
remain unidentified in the THCIC Practitioner Reference files.

==
PROVIDER: Tyler County Hospital
THCIC ID: 569000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No comment.

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PROVIDER: Ascension Seton Edgar B Davis
THCIC ID: 597000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Seton Edgar B. Davis, a member of the Seton Family of Hospitals, is a general
acute care, 25-bed facility committed to providing quality inpatient and
outpatient services for residents of Caldwell and surrounding counties. Seton
Edgar B. Davis offers health education and wellness programs. In addition,
specialists offer a number of outpatient specialty clinics providing
area residents local access to the services of medical specialists. Seton Edgar
B. Davis is located at 130 Hays St. in Luling, Texas. This facility is
designated by the Center for Medicare & Medicaid Services as a Critical Access
Hospital and is fully accredited by the Joint Commission on Accreditation of
Healthcare Organizations under its Critical Access program.
All physician license numbers and names have been validated with the Physician
and the Texas State Board of Medical Examiner website as accurate but some
remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet
statutory requirements.

==
PROVIDER: St Davids South Austin Hospital
THCIC ID: 602000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
E- 617 - Other Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and mock billing
practices
All errors have been reviewed and corrected to the best of the facilities
ability.

==
PROVIDER: Round Rock Medical Center
THCIC ID: 608000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 690 - Invalid Physician 2 (ED Attending) Identifier for ED claim: All claims
reviewed, NPI# for ER physicians group correct as entered, patient left prior to
physician evaluation
All errors have been reviewed and corrected to the best of the facilities
ability.

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

than 1% of the encounter volume.

Diagnosis and Procedures

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

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

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Length of Stay

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Admit Source data for Normal Newborn

When the Admit type is equal to 'newborn', the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of

illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to 'normal delivery' as the admission source. Therefore, admission source does not always give an accurate picture. If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Allen recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Palestine Regional Medical Center
THCIC ID: 629001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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PROVIDER: Hamilton General Hospital
THCIC ID: 640000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

All data reviewed for accuracy as of 11/05/2021.

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PROVIDER: Kindred Hospital-San Antonio
THCIC ID: 645000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care
settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 140 records are correctly reported as Elective.
(Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

The length of stay data element contained in the state's certification file is only three characters long. Thus, any patients discharged with a length of stay

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

==
PROVIDER: UT Southwestern University Hospital-Zale Lipshy
THCIC ID: 653001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E-617 Procedure dates are correct
E-618 Procedure dates are correct
E-656 The admission type is correct

E-665 999999999 was entered-SSN could not be obtained

==
PROVIDER: UT Southwestern University Hospital-Zale Lipshy Rehab
THCIC ID: 653003
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No Errors

==
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
'apples to apples' comparison cannot be made, which makes it difficult to obtain

an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
The length of stay data element contained in the state's certification file is only three characters long. Thus, any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to 'newborn', the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to 'normal delivery' as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Allen recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better

clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==
PROVIDER: HCA Houston Healthcare Kingwood
THCIC ID: 675000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

UNABLE TO CORRECT ERRORS RELATED TO:
NPI AS IT IS ASSIGNED TO ORGANIZAITON AND NOT AN INDIVIDUAL
BIRTHDATE AND ADMISSION TYPE FOR NEWBORN TRANSFERRED FROM OUTSIDE FACILITY FOUR DAYS AFTER BIRTH

==
PROVIDER: Kindred Hospital-Houston Medical Center
THCIC ID: 676000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long -term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care
settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 247 records are correctly reported as Elective.
(Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
===
PROVIDER: North Central Baptist Hospital
THCIC ID: 677001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

I hereby certify 2nd quarter 2021 IP. 4961 encounters. On behalf of (Removed by
THCIC),
CFO at North Central Baptist Hospital. (Removed by THCIC), Director
Revenue Analysis at North Central Baptist Hospital.

*Potential confidential information removed by THCIC.
===
PROVIDER: CHRISTUS Spohn Hospital Alice
THCIC ID: 689401
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Certified gmr

===
PROVIDER: Kindred Hospital-Tarrant County
THCIC ID: 690000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long -term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care

settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 94 records are correctly reported as Elective.
(Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital Houston NW
THCIC ID: 706000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care
settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 161 records are correctly reported as Elective.
(Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Texas Health Seay Behavioral Health Hospital
THCIC ID: 720000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

than 1% of the encounter volume.

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to 'newborn', the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of

illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to 'normal delivery' as the admission source. Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Allen recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record.   In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both 'HMO, and PPO' are categorized as 'Commercial PPO'. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically, actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

===
PROVIDER: Kindred Hospital Clear Lake
THCIC ID: 720402
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 166 records are correctly reported as Elective. (Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An 'apples to apples' comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely

collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

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Discharge Disposition

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

===
PROVIDER: Kindred Hospital El Paso
THCIC ID: 727100
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 109 records are correctly reported as Elective.
(Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
===

PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
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actual hospital billing process. Errors can occur due to this additional
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Patient diagnoses and procedures for a particular hospital stay are coded by the
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Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
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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
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state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99

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

Length of Stay

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Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

categorized as 'Commercial PPO'. Thus, any true managed care comparisons by
contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges.
It is important to note that charges are not equal to actual payments received
by the hospital or hospital cost for performing the service. Typically, actual
payments are much less than charges due to managed care-negotiated discounts and
denial of payment by insurance companies. Charges also do not reflect the actual
cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some
patient discharges to "home" as opposed to rehab. THR will communicate this
issue and the plan to address this issue in writing to the THCIC Executive
Director.

==
PROVIDER: Texas Health Springwood Behavioral Health Hospital
THCIC ID: 778000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Baylor Scott & White Heart & Vascular Hospital Dallas
THCIC ID: 784400
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Heart & Vascular Hospital Dallas
THCIC ID 784400
2nd Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

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==============================================================================
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PROVIDER: Harlingen Medical Center

THCIC ID: 788002
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No errors on inpatient data

==
PROVIDER: Kindred Hospital Sugar Land
THCIC ID: 792700
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care
settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referrals are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 190 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Ascension Seton Southwest
THCIC ID: 797500
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

==
PROVIDER: Ascension Seton Northwest
THCIC ID: 797600
 QUARTER: 2
    YEAR: 2021

Certified With Comments

These data are submitted by the hospital as their best effort to meet statutory
requirements.
2021Q2 Inpatient submission accuracy = 99.71%
5 errors on 5 inpatient claims (representing only 0.29% of claims) were unable
to be corrected prior to certification. The primary resources with user
permissions that can technically resolve the data errors do not have the
expertise to resolve all errors; and in some cases the errors are not
resolvable. SSN errors (3) were due to incomplete or inaccurate information
entered; and admission type errors (1) were due to incorrect code mappings. For
physician ID errors (1), all Physician license numbers and names have been
validated by the Physician and the Texas State Board of Medical Examiners
website, but some remain unidentified in the THCIC Practitioner Reference files.

==
PROVIDER: Kindred Hospital Tarrant County Fort Worth SW
THCIC ID: 800000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

indred Hospital is a long –term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care
settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 147 records are correctly reported as Elective.
(Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
 QUARTER: 2
    YEAR: 2021

Certified With Comments

The Q2 2021 All Data/information in these files contain accurate data in areas
such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain
duplicates/missing claims but the file was reviewed and all corrections made

==
PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100

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 QUARTER: 2
    YEAR: 2021
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Certified With Comments

The Q2 2021 All Data/information in these files contain accurate data in areas
such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain
duplicates/missing claims but the file was reviewed and all corrections made


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================================================================================
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PROVIDER: Baylor Scott & White Medical Center-Plano
THCIC ID: 814001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center-Plano
THCIC ID 814001
2nd Qtr 2021 – Inpatient
Accuracy rate – 99.81%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported


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================================================================================
```
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to 'newborn', the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural

birth, or information not available. The best way to focus on severity of
illness regarding an infant would be to check the infant's diagnosis at
discharge, not the admitting source code. Many hospital information systems and
registration process defaults to 'normal delivery' as the admission source.
Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal
neonates using the admit source to identify the cases, the data will reflect
premature and sick babies mixed in with the normal newborn data. Texas Health
Allen recommends use of ICD10 coding data to identify neonates. This
methodology will ensure correct identification of the clinical status of the
newborn admission.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be
creating guidelines for use by hospitals. These guidelines will provide better
clarity for the accurate collection of this data. Hospitals do not routinely
collect race and ethnicity as part of the admission process, that this has been
added to meet the THCIC requirement. Our admissions staff indicates that many
patients are very sensitive about providing race and ethnicity information.
Therefore, depending on the circumstances of the patient's admission, race and
ethnicity data may be subjectively collected. Therefore, the race and ethnicity
data may not provide an accurate representation of the patient population for a
facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data
required by the state that is not contained within the standard UB92 billing
record.   In order to meet this requirement, each payer identifier must be
categorized into the appropriate standard and non-standard source of payment
value. These values might not accurately reflect the hospital payer information,
because those payers identified contractually as both 'HMO, and PPO' are
categorized as 'Commercial PPO'. Thus, any true managed care comparisons by
contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges.
It is important to note that charges are not equal to actual payments received
by the hospital or hospital cost for performing the service. Typically, actual
payments are much less than charges due to managed care-negotiated discounts and
denial of payment by insurance companies. Charges also do not reflect the actual
cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some
patient discharges to "home" as opposed to rehab. THR will communicate this
issue and the plan to address this issue in writing to the THCIC Executive
Director.

==
PROVIDER: Allegiance Behavioral Health Center-Plainview
THCIC ID: 816001
 QUARTER: 2
    YEAR: 2021

Certified With Comments

The errors were noted and corrections will be made moving forward to next quarter review. The 5 noted errors were not corrected on time by the Administrator.

==
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An 'apples to apples' comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to

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

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

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

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

data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==
PROVIDER: University Behavioral Health-Denton
THCIC ID: 826800
 QUARTER: 2
    YEAR: 2021

Certified With Comments

All information has been reviewed

==
PROVIDER: Heart Hospital-Austin
THCIC ID: 829000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 617 - Other Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and mock billing practices
E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices

All errors have been reviewed and corrected to the best of the facilities
ability.

==
PROVIDER: Mayhill Hospital
THCIC ID: 831700
 QUARTER: 2
     YEAR: 2021

Certified With Comments

Reviewed all accounts

==
PROVIDER: St Joseph Medical Center
THCIC ID: 838600
 QUARTER: 2
     YEAR: 2021

Certified With Comments

   St. Joseph Medicine Center (Removed by THCIC) certify 2nd Quarter 2021. We have
100%
accuracy rate.

*Potential confidential information removed by THCIC.
==
PROVIDER: El Paso LTAC Hospital
THCIC ID: 841300
 QUARTER: 2
     YEAR: 2021

Certified With Comments

I certify 2Q2021 as complete, correct, showing no errors.

==
PROVIDER: Baylor Scott & White The Heart Hospital Plano
THCIC ID: 844000
 QUARTER: 2
     YEAR: 2021

Certified With Comments

Baylor Scott & White The Heart Hospital Plano
THCIC ID 844000
2nd Qtr 2021 Inpatient

Accuracy rate -100%
No comments needed.

==
PROVIDER: Baylor Scott & White Continuing Care Hospital
THCIC ID: 850300
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Continuing Care Hospital
THCIC ID 850300
2nd Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Dell Children's Medical Center (DCMC) is the only standalone children's hospital
in the Central Texas region. DCMC serves severely ill and/or injured children
requiring intensive resources which increase the hospital's costs of care,
lengths of stay and mortality rates. In addition, the hospital includes a
Neonatal Intensive Care Unit (NICU) which serves very seriously ill infants,
which substantially increases costs of care, lengths of stay and mortality
rates.
These data are submitted by the hospital as their best effort to meet statutory
requirements.
2021Q2 Inpatient submission accuracy = 99.95%
1 error on 1 inpatient claim (representing only 0.05% of claims) was unable to
be corrected prior to certification. The primary resources with user permissions
that can technically resolve the data errors do not have the expertise to
resolve all errors; and in some cases the errors are not resolvable. This
admission source error was due to incorrect code mappings.

==
PROVIDER: Baylor Scott & White Medical Center Round Rock
THCIC ID: 852600
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Round Rock
THCIC ID 852600
2nd Qtr 2021 – Inpatient
Accuracy rate – 99.94%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

===
PROVIDER: Physicians Surgical Hospital-Quail Creek
THCIC ID: 852900
 QUARTER: 2
    YEAR: 2021

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. No errors
detected on the certification report.

===
PROVIDER: Physicians Surgical Hospital-Panhandle Campus
THCIC ID: 852901
 QUARTER: 2
    YEAR: 2021

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. No errors
detected on the certification report.

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================================================================================
PROVIDER: Central Texas Rehab Hospital
THCIC ID: 854400
 QUARTER: 2
    YEAR: 2021


Certified With Comments

Kindred Hospital is a Rehabilitation care hospital that provides an hospital
level of care and services to patient requiring a Rehab hospitalization.
Kindred hospital admissions are sorely based on referrals from various health
care settings; such as: short term acute care; skilled nursing; sub-acute and in
some cases direct admits from home.  All referral are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance.  Therefore, all 177 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.
================================================================================
PROVIDER: El Paso Behavioral Health System
THCIC ID: 858600
 QUARTER: 2
    YEAR: 2021


Certified With Comments

5 Medicare admissions with combined bills; 4 accounts with no charges due to
same day admission/discharge dates (VOID admissions)



================================================================================
PROVIDER: Texas Health Hospital Rockwall
THCIC ID: 859900
 QUARTER: 2
    YEAR: 2021


Certified With Comments

The Q2 2021 All Data/information in these files contain accurate data in areas
such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain
duplicates/missing claims but the file was reviewed and all corrections made



================================================================================
PROVIDER: Ascension Seton Williamson
THCIC ID: 861700
 QUARTER: 2
    YEAR: 2021


Certified With Comments
```

These data are submitted by the hospital as their best effort to meet statutory requirements.
2021Q2 Inpatient submission accuracy = 99.50%
13 errors on 10 inpatient claims (representing only 0.50% of claims) were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable. SSN errors (2) and zip code errors (2) were due to incomplete or inaccurate information entered; country errors (2) were due to missing information; race/ethnicity errors (2) were due to submissions not matching lookup table; and admission source error (1) was due to incorrect code mappings. For physician ID errors (1), all Physician license numbers and names have been validated by the Physician and the Texas State Board of Medical Examiners website, but some remain unidentified in the THCIC Practitioner Reference files.

===
PROVIDER: The Hospitals of Providence East Campus
THCIC ID: 865000
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No comment needed.

===
PROVIDER: Methodist Hospital Stone Oak
THCIC ID: 874100
 QUARTER: 2
    YEAR: 2021

Certified With Comments

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices
E- 617 - Other Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and mock billing practices
All errors have been reviewed and corrected to the best of the facilities ability.

===
PROVIDER: Kindred Hospital Dallas Central
THCIC ID: 914000

QUARTER: 2
   YEAR: 2021

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital
level of care and services to patient requiring a long hospitalization. Kindred
hospital admissions are sorely based on referrals from various health care
settings; such as: short term acute care; skilled nursing; sub-acute and in some
cases direct admits from home. All referrals are screen by our centralized
admission department prior to admission and scheduled for admission at least 24
hours in advance. Therefore, all 122 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Ascension Seton Hays
THCIC ID: 921000
 QUARTER: 2
   YEAR: 2021

Certified With Comments

These data are submitted by the hospital as their best effort to meet statutory
requirements.
2021Q2 Inpatient submission accuracy = 99.75%
7 errors on 6 inpatient claims (representing only 0.25% of claims) were unable
to be corrected prior to certification. The primary resources with user
permissions that can technically resolve the data errors do not have the
expertise to resolve all errors; and in some cases the errors are not
resolvable. Admission type/admission source errors (2) were due to incorrect
code mappings; and race/ethnicity errors (1) were due to submissions not
matching lookup table. For physician ID errors (3), all Physician license
numbers and names have been validated by the Physician and the Texas State Board
of Medical Examiners website, but some remain unidentified in the THCIC
Practitioner Reference files.

==
PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
 QUARTER: 2
   YEAR: 2021

Certified With Comments

The Q2 2021 All Data/information in these files contain accurate data in areas
such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain
duplicates/missing claims but the file was reviewed and all corrections made

```
================================================================================
```
PROVIDER: Carrollton Springs
THCIC ID: 969500
 QUARTER: 2
    YEAR: 2021

Certified With Comments

All errors are related to SSN. No Social Security Numbers were available for 17
accounts. Our staff entered all zeros (000-00-0000) instead of all 9s. I tried
to correct the errors but there was no option in Correction tab. It was blank.


```
================================================================================
```
PROVIDER: Baylor Scott & White Medical Center McKinney
THCIC ID: 971900
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center McKinney
THCIC ID 971900
2nd Qtr 2021 Inpatient
Accuracy rate – 99.85%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported


```
================================================================================
```
PROVIDER: Texas Health Harris Methodist Hospital Alliance
THCIC ID: 972900
 QUARTER: 2
    YEAR: 2021

Certified With Comments

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

programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==

PROVIDER: Oceans Behavioral Hospital Abilene
THCIC ID: 973240
 QUARTER: 2
    YEAR: 2021

Elected Not to Certify

Data is not correct due to uploading issue.

==
PROVIDER: Mesa Springs
THCIC ID: 973430
 QUARTER: 2
    YEAR: 2021

Certified With Comments

The 2rd Qtr. 2021 data for ethnicity is incorrect.   We are working on our
system to be able to accurately report this statistic.

==
PROVIDER: Medical City Alliance
THCIC ID: 974490
 QUARTER: 2
    YEAR: 2021

Certified With Comments

INFORMATION IS VALID

==
PROVIDER: Baylor Scott & White Medical Center Marble Falls
THCIC ID: 974940
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Marble Falls
THCIC ID 974940
2nd Qtr 2021 Inpatient
Accuracy rate –   99.84%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

```
================================================================================
PROVIDER: JPS Health Network - Trinity Springs North
THCIC ID: 975121
 QUARTER: 2
    YEAR: 2021


Certified With Comments

JPS Health Network
Comments on THCIC Data Submission
Introduction
John Peter Smith Hospital (JPSH) is operated by JPS Health Network
under the auspices of the Tarrant County Hospital District.  The JPS Health
Network is accredited by the Joint Commission. In addition, JPSH holds
Joint Commission accreditation as a hospital.
JPSH is the only Texas Department of Health certified Level I Trauma
Center in Tarrant County and includes the only psychiatric emergency center in
the county.  The hospital's services include intensive care for adults and
newborns, an AIDS treatment center, a full range of obstetrical and
gynecological services, adult inpatient care and an inpatient mental health
treatment facility.
JPSH is a major teaching hospital offering, or providing through co-operative
arrangements, postdoctoral training in orthopedics, obstetrics and gynecology,
psychiatry, surgery, oral and maxillofacial surgery, radiology, sports medicine,
podiatry and pharmacy. The family medicine residency is the largest
hospital-based family medicine residency program in the nation.
In addition to JPSH, the JPS Health Network operates community health
centers located in medically underserved areas of Tarrant County; school-based
health clinics; outpatient programs for pregnant women, behavioral health and
cancer patients; and a wide range of wellness education programs.
JPSH has confirmed that for errors related to "Other Procedure Date must be on
or after the 3rd day before the Admission Date", patient was in observation
status at the time of the procedure. Procedure date and time are accurate based
on when the procedure was completed.
After review of the required THCIC claim submission data criteria, JPSH has
amended their reporting criteria to include previously omitted closed accounts
and align with THCIC requirements.  The change will impact reported data
starting 4th Quarter 2021 and may change overall reporting volume.



================================================================================
PROVIDER: Kindred Hospital San Antonio Central
THCIC ID: 975155
 QUARTER: 2
    YEAR: 2021


Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital
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level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 103 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Palms Behavioral Health
THCIC ID: 975164
 QUARTER: 2
    YEAR: 2021

Certified With Comments

NPI number for Attending Practitioner ID was incorrect, we used the group NPI instead of the individual practitioner NPI

==
PROVIDER: Baylor Scott & White Medical Center Lakeway
THCIC ID: 975165
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Lakeway
THCIC ID 975165
2nd Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==
PROVIDER: Texas Health Hospital Clearfork
THCIC ID: 975167
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

Director.

```
================================================================================
PROVIDER: Eating Recovery Center
THCIC ID: 975178
 QUARTER: 2
    YEAR: 2021
```

Certified With Comments

includes 9 of the 1st quarter in error

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================================================================================
PROVIDER: The Hospitals of Providence Transmountain Campus
THCIC ID: 975188
 QUARTER: 2
    YEAR: 2021
```

Certified With Comments

No comments required

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================================================================================
PROVIDER: Dell Seton Medical Center at The University of Texas
THCIC ID: 975215
 QUARTER: 2
    YEAR: 2021
```

Certified With Comments

As the public teaching hospital in Austin and Travis County, Dell Seton Medical
Center at The University of Texas (DSMCUT) serves patients who are often unable
to access primary care. It is more likely that these patients will present in
the later more complex stage of their disease.
It is also a regional referral center, receiving patient transfers from
hospitals not able to serve a complex mix of patients. Treatment of these very
complex, seriously ill patients increases the hospital's cost of care, length of
stay and mortality rates.
As the Regional Level I Trauma Center, DSMCUT serves severely injured patients.
Lengths of stay and mortality rates are most appropriately compared to other
trauma centers.
All physician license numbers and names have been validated with the Physician
and the Texas State Board of Medical Examiner website as accurate but some
remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory
requirements."

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================================================================================
PROVIDER: CHRISTUS Dubuis Hospital Beaumont
THCIC ID: 975255
 QUARTER: 2
    YEAR: 2021


Certified With Comments


Certified as correct.



================================================================================
PROVIDER: Baylor Scott & White Medical Center Centennial
THCIC ID: 975285
 QUARTER: 2
    YEAR: 2021


Certified With Comments


Baylor Scott & White Medical Center Centennial
THCIC ID 975285
2nd Qtr 2021 Inpatient
Accuracy rate - 100%
No comments needed.



================================================================================
PROVIDER: Baylor Scott & White Medical Center Lake Pointe
THCIC ID: 975286
 QUARTER: 2
    YEAR: 2021


Certified With Comments


Baylor Scott & White Medical Center Lake Point
THCIC ID 975286
2nd Qtr 2021 Inpatient
Accuracy rate – 99.90%
Errors from the 2nd Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.



================================================================================
PROVIDER: UT Health East Texas Carthage Hospital
THCIC ID: 975294
 QUARTER: 2
    YEAR: 2021
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Certified With Comments

No errors

==
PROVIDER: UT Health East Texas Henderson Hospital
THCIC ID: 975295
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No errors

==
PROVIDER: UT Health East Texas Tyler Regional Hospital
THCIC ID: 975299
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Errors include:
Unknown date of birth for trauma patient
NP listed as a physician
HSPCS code issue

==
PROVIDER: UT Health East Texas Rehabilitation Hospital
THCIC ID: 975301
 QUARTER: 2
    YEAR: 2021

Certified With Comments

One record has an invalid social security number, after exhausting all possible
research we are accepting that claim as is.

==
PROVIDER: HCA Houston Healthcare North Cypress
THCIC ID: 975321
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Corrections made to the best of our ability at the time of certification.

==
PROVIDER: Baylor Scott & White Medical Center Pflugerville
THCIC ID: 975340
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Pflugerville
THCIC ID 975340
2nd Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==
PROVIDER: Baylor Scott & White The Heart Hospital McKinney
THCIC ID: 975385
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White The Heart Hospital McKinney
THCIC ID 975385
2nd Qtr 2021 – Inpatient
Accuracy rate – 100%
No comments needed.

==
PROVIDER: Baylor Scott & White Medical Center Buda
THCIC ID: 975391
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Buda
THCIC ID 975391
2nd Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==

PROVIDER: Legent Orthopedic Hospital
THCIC ID: 975413
 QUARTER: 2
    YEAR: 2021

Certified With Comments

I DO NOT FEEL THIS INFORMATION IS ACCURATE DUE TO REPORT ISSUES AND CORRECTIONS.

==
PROVIDER: Ascension Seton Bastrop
THCIC ID: 975418
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Ascension Seton Bastrop, a member of Ascension Texas, is a state of the art
hospital and medical office building located along highway 71 that services
residents of Bastrop and surrounding counties. The wide range of specialties and
services provided include: 24 hour emergency care, inpatient services, primary
care and family medicine, outpatient maternal fetal medicine, heart and vascular
care including vascular imaging services, cardiac rehabilitation, outpatient
neurosurgery care, outpatient respiratory services including pulmonary function
tests and arterial blood gas testing, womens diagnostics services including
mammography and dexa, and onsite imaging (CT, X-ray, ultrasound) and laboratory
services.
All physician license numbers and names have been validated with the Physician
and the Texas State Board of Medical Examiner website as accurate but some
remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory
requirements

==
PROVIDER: United Memorial Medical Center Sugar Land Hospital
THCIC ID: 975780
 QUARTER: 2
    YEAR: 2021

Certified With Comments

(Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Texas Health Hospital Frisco
THCIC ID: 975783
 QUARTER: 2

YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is 'over and above' the
actual hospital billing process. Errors can occur due to this additional
programming, but the public should not conclude that billing data sent to our
payers is inaccurate. These errors have been corrected to the best of our
knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD-10-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
'apples to apples' comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission or
developed an infection during their hospitalization. This makes it difficult to
obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-10-CM data on each patient but has limited the number of diagnoses
and procedures to the first 25 diagnoses codes and the first 25 procedure codes.

As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

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Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges.
It is important to note that charges are not equal to actual payments received
by the hospital or hospital cost for performing the service. Typically, actual
payments are much less than charges due to managed care-negotiated discounts and
denial of payment by insurance companies. Charges also do not reflect the actual
cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some
patient discharges to "home" as opposed to rehab. THR will communicate this
issue and the plan to address this issue in writing to the THCIC Executive
Director.

==
PROVIDER: Baylor Scott & White Medical Center Austin
THCIC ID: 975789
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Baylor Scott and White Medical Center Austin
THCIC ID 975789
2nd Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==
PROVIDER: The Hospitals of Providence Spine & Pain Management Center
THCIC ID: 975803
 QUARTER: 2
    YEAR: 2021

Certified With Comments

No comments required

==
PROVIDER: Wellbridge Hospital of Fort Worth
THCIC ID: 975835
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Incorrect Race/Ethnicity in our EHR system was discovered for 2nd quarter data.
Since this discovery, the issue is resolved and has been updated with the
correct mapping on race/ethnicity for the all claims in the EHR system.

```
================================================================================
PROVIDER: Methodist Southlake Medical Center
THCIC ID: 975966
 QUARTER: 2
    YEAR: 2021

Certified With Comments

Contains claims from June 2020 only as that is when Methodist fully owned the
facility
```