

Outpatient Facility Comments, 1Q2015.txt

General Comments on 1st Quarter 2015 Data

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

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

PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 1
YEAR: 2015

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

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PROVIDER: Baylor Scott & White Medical Center-Garland
THCIC ID: 027000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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

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

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

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

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PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
QUARTER: 1
YEAR: 2015

Certified with Comments

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PROVIDER: Baylor Medical Center at Carrollton
THCIC ID: 042000
QUARTER: 1
YEAR: 2015

Certified with Comments

Baylor Medical Center Carrollton OUTPATIENT DATA
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THCIC ID: 042000
QUARTER: 1
YEAR: 2015

CERTIFIED WITH COMMENTS

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PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
QUARTER: 1
YEAR: 2015

Certified with Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of December 1, 2015. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgments about patient care.

Submission Timing

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures

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

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using ICD-9-CM prior to 10-1-2015 and CPT. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are

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

There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore mortality ratios may be accurate for reporting standards but overstated.

Given the current certification software, due to hospital volumes, it is not feasible to perform encounter level audits and edits. To meet the state's mandates to submit hospital outpatient visits with specific procedures, Texas Health Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format.

The quarterly data to the best of our knowledge is accurate and complete given the above.

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PROVIDER: San Angelo Community Medical Center
THCIC ID: 056000
QUARTER: 1
YEAR: 2015

Elected Not to Certify

elect not to certify

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PROVIDER: CHI St Lukes Health Baylor College of Medicine Medical Center
THCIC ID: 118000
QUARTER: 1
YEAR: 2015

Certified with Comments

The data reports for Quarter 1, 2015 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

Payer Source

A payer source mapping discrepancy has been identified. The HIS vendor is working towards a resolution.

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PROVIDER: Faith Surgical Center
THCIC ID: 120100
QUARTER: 1
YEAR: 2015

Certified with Comments

Change of Tax ID submitted. ASC was sold.

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PROVIDER: University Medical Center
THCIC ID: 145000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

Diagnosis and Procedures

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

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PROVIDER: The Heart Hospital Baylor Denton
THCIC ID: 208100
QUARTER: 1
YEAR: 2015

Certified with Comments

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PROVIDER: Medical Center-Plano
THCIC ID: 214000
QUARTER: 1
YEAR: 2015

Certified with Comments

Information Valid

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PROVIDER: DeHaven Surgical Center
THCIC ID: 228002
QUARTER: 1
YEAR: 2015

Certified with Comments

submitted by Lisa Myers 903-595-7573

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PROVIDER: Texas Health Harris Methodist Hospital-Fort worth
THCIC ID: 235000
QUARTER: 1
YEAR: 2015

Certified with Comments

Outpatient Facility Comments, 1Q2015.txt

Data Content

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PROVIDER: Columbia Medical Center-McKinney
THCIC ID: 246000
QUARTER: 1
YEAR: 2015

Certified with Comments

Information Valid

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PROVIDER: Wise Regional Health System
THCIC ID: 254001
QUARTER: 1
YEAR: 2015

Certified with Comments

The data for 1Q2015 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THCIC; any changes would be information collected or updated during the normal course of business.

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PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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

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PROVIDER: Baylor Scott & white Medical Center at waxahachie
THCIC ID: 285000
QUARTER: 1
YEAR: 2015

Certified with Comments

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PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
QUARTER: 1
YEAR: 2015

Certified with Comments

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PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 1
YEAR: 2015

Certified with Comments

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
QUARTER: 1
YEAR: 2015

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PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 1
YEAR: 2015

Certified with Comments

Baylor Medical Center at BUMC OUTPATIENT DATA
THCIC ID: 331000
QUARTER: 1
YEAR: 2015

CERTIFIED WITH COMMENTS

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

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

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

Outpatient Facility Comments, 1Q2015.txt

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

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

PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 1
YEAR: 2015

Certified with Comments

Cook Children's Medical Center has submitted and certified 1st QUARTER 2015 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 1st QUARTER OF 2015.

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

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

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

PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000
QUARTER: 1
YEAR: 2015

Outpatient Facility Comments, 1Q2015.txt

Certified with Comments

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

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

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

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

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

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PROVIDER: Denton Regional Medical Center
THCIC ID: 336001
QUARTER: 1
YEAR: 2015

Certified with Comments

INFORMATION VALID

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PROVIDER: Medical Arts Hospital
THCIC ID: 341000
QUARTER: 1
YEAR: 2015

Elected Not to Certify

Being that the data is so voluminous I cannot accurately certify with 100% accuracy.

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PROVIDER: Baylor All Saints Medical Center-Fort worth
THCIC ID: 363000
QUARTER: 1
YEAR: 2015

Certified with Comments

PROVIDER: Baylor All Saints Medical Center-Fort worth
THCIC ID: 363000
QUARTER: 1
YEAR: 2015

CERTIFIED WITH COMMENTS

Outpatient Facility Comments, 1Q2015.txt

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

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

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

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

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PROVIDER: Reeves County Hospital
THCIC ID: 367000
QUARTER: 1
YEAR: 2015

Certified with Comments
Issues with payor source.

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PROVIDER: Victoria Surgery Center
THCIC ID: 396003
QUARTER: 1
YEAR: 2015

Certified with Comments
To the best of my knowledge, all data is correct.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 1
YEAR: 2015

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

JPSH was the first Texas Department of Health certified Level I Trauma
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Outpatient Facility Comments, 1Q2015.txt

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

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

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

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

Diagnosis and Procedures

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always

Outpatient Facility Comments, 1Q2015.txt

possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

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Diagnosis and Procedures

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

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

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Race/Ethnicity

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PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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PROVIDER: DeTar Hospital-North
THCIC ID: 453001
QUARTER: 1
YEAR: 2015

Certified with Comments

Outpatient Facility Comments, 1Q2015.txt

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PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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Outpatient Facility Comments, 1Q2015.txt

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Length of Stay

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Race/Ethnicity

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PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

1894. The Parkland System is a \$1.271 billion enterprise that is licensed for 862 beds and employs approximately 10,504 staff. 84,338 patients received outpatient care in the clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

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

PROVIDER: Seton Medical Center
THCIC ID: 497000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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

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

PROVIDER: Methodist Richardson Medical Center
THCIC ID: 549000
QUARTER: 1
YEAR: 2015

Certified with Comments

There are some observation claims missing in the this quarter that will be submitted in with 2015 2nd Quarter.

PROVIDER: Bush Renner
THCIC ID: 549001
QUARTER: 1
YEAR: 2015

Certified with Comments

There are some observation claims missing in the this quarter that will be submitted in with 2015 2nd Quarter.

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PROVIDER: Bellville St Joseph Health Center
THCIC ID: 552000
QUARTER: 1
YEAR: 2015

Certified with Comments

Certified by Karen McEuen

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PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
QUARTER: 1
YEAR: 2015

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.

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PROVIDER: Cypress Fairbanks Medical Center
THCIC ID: 606000
QUARTER: 1

YEAR: 2015

Certified with Comments

certify

PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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Outpatient Facility Comments, 1Q2015.txt

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Race/Ethnicity

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

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

PROVIDER: Trinity Mother Frances Rehab Hospital
THCIC ID: 692000
QUARTER: 1
YEAR: 2015

Elected Not to Certify

The Outpatient Department of Trinity Mother Frances Rehabilitation is no longer providing physical medicine and rehabilitation services which include physical therapy, occupational therapy and speech therapy. Due to internal processes and constraints, outpatient data was submitted as available for processing and may not coincide with appropriate quarter timeframes.

PROVIDER: Our Childrens House Baylor
THCIC ID: 710000
QUARTER: 1
YEAR: 2015

Certified with Comments

The OP Discharges total appears materially low I count a total of 3,181. This report has 508. But the distribution mixes appear reasonable. It does not appear that same day surgeries are the only outpatient cases populating the THCIC report, but they appear to be the majority (I count 349 in this period). Until a report is available from THCIC that gives a listing of the individual accounts included here we wont be able to identify a common pattern causing the discrepancies.

PROVIDER: Ennis Regional Medical Center
THCIC ID: 714500
QUARTER: 1
YEAR: 2015

Certified with Comments

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

Outpatient Facility Comments, 1Q2015.txt

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PROVIDER: Texas Midwest Surgery Center
THCIC ID: 718200
QUARTER: 1
YEAR: 2015

Certified with Comments

Approved

=====

PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
QUARTER: 1
YEAR: 2015

Certified with Comments

AS IS.

=====

PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

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

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

Diagnosis and Procedures

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

Outpatient Facility Comments, 1Q2015.txt

apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Outpatient Facility Comments, 1Q2015.txt

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PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
QUARTER: 1
YEAR: 2015

Certified with Comments

The data reports for Quarter 1, 2015 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

Payer Source

A payer source mapping discrepancy has been identified. The HIS vendor is working towards a resolution.

=====

PROVIDER: Green Oaks Hospital
THCIC ID: 766000
QUARTER: 1
YEAR: 2015

Certified with Comments

INFORMATION VALID

=====

PROVIDER: Baylor Heart & Vascular Center
THCIC ID: 784400
QUARTER: 1
YEAR: 2015

Certified with Comments

The OP Discharges totals appear materially low But the distribution mixes all appear reasonable. I suspect the services we provide to BUMC and BAS inpatients under registered BHVH outpatient accounts could be responsible for some of the discrepancies. But until a report is available from THCIC that gives a listing of the individual accounts included here we wont be able to identify a common pattern causing the discrepancies

=====

PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
QUARTER: 1
YEAR: 2015

Outpatient Facility Comments, 1Q2015.txt

Certified With Comments

Certified to the best of my knowledge.

=====

PROVIDER: Christus St Michael Hospital Atlanta
THCIC ID: 788003
QUARTER: 1
YEAR: 2015

Certified With Comments

Certified to the best of my knowledge.

=====

PROVIDER: St Lukes The woodlands Hospital
THCIC ID: 793100
QUARTER: 1
YEAR: 2015

Certified With Comments

The data reports for Quarter 1, 2015 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

Payer Source

A payer source mapping discrepancy has been identified. The HIS vendor is working towards a resolution.

=====

PROVIDER: Hill Country Memorial Surgery Center
THCIC ID: 793300
QUARTER: 1
YEAR: 2015

Certified With Comments

certified by Pam

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PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
QUARTER: 1

Outpatient Facility Comments, 1Q2015.txt

YEAR: 2015

Certified with Comments

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

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

PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
QUARTER: 1
YEAR: 2015

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: Medical Village Surgery Center
THCIC ID: 804300
QUARTER: 1
YEAR: 2015

Certified with Comments

There is one instance where the procedure date was inadvertently entered in lieu of the patients date of birth.

PROVIDER: Community Surgery Center
THCIC ID: 807500
QUARTER: 1
YEAR: 2015

Elected Not to Certify

elect not to certify

PROVIDER: Swiss Avenue Surgicenter
THCIC ID: 809700
QUARTER: 1
YEAR: 2015

Certified with Comments

Rev Codes for all G codes submitted on claims are 0490-I was unable to correct those claims prior to certification.

The G codes are not codes that have revenue tied to them, they are simply

Outpatient Facility Comments, 1Q2015.txt
"Quality Tracking" codes to communicate with the state/CMS.

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PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
QUARTER: 1
YEAR: 2015

Certified with Comments

Files may contain duplicate and/or missing claims

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PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
QUARTER: 1
YEAR: 2015

Certified with Comments

Files may contain duplicate and/or missing claims

=====

PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
QUARTER: 1
YEAR: 2015

Certified with Comments

Information Valid

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PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
QUARTER: 1
YEAR: 2015

Certified with Comments

Submission Timing

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

Physician Identification

All physician license numbers and names have been validated as accurate against a physician reference file that is derived from information provided by the Texas Board of Medical Examiners. Those physicians not yet assigned a state license number at the time of data submission are given temporary numbers by the hospital for state reporting purposes. Due to the "lag" time between when the physician is licensed and when THCIC receives the information, some physicians may remain unidentified in the THCIC Practitioner Reference Files.

The THCIC minimum data set houses only two (2) physician fields; Attending

Outpatient Facility Comments, 1Q2015.txt

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

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time.

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

Cost/ Revenue Codes

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

Outpatient Facility Comments, 1Q2015.txt

patient needs.

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
QUARTER: 1
YEAR: 2015

Certified with Comments

Files may contain duplicate and/or missing claims

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PROVIDER: Spinecare
THCIC ID: 816900
QUARTER: 1
YEAR: 2015

Elected Not to Certify

DATA IS GENERATED FROM FACILITY'S SCHEDULING AND BILLING SOFTWARE. FACILITY CANNOT GUARANTEE 100% OF ITS ACCURACY

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PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

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

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International

Outpatient Facility Comments, 1Q2015.txt

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

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

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Outpatient Facility Comments, 1Q2015.txt

Cost/ Revenue Codes

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

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PROVIDER: Memorial Hermann Surgery Center Woodlands
THCIC ID: 825400
QUARTER: 1
YEAR: 2015

Certified with Comments

No comments

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PROVIDER: Simmons Ambulatory Surgery Center
THCIC ID: 843300
QUARTER: 1
YEAR: 2015

Certified with Comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a \$1.271 billion enterprise that is licensed for 862 beds and employs approximately 10,504 staff. Approximately 1,390 patients received outpatient care in the clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

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

=====

PROVIDER: Cook Childrens Northeast Hospital
THCIC ID: 850200
QUARTER: 1
YEAR: 2015

Certified with Comments

The Data for Patient race is incorrect due to an issue with the set up of the interface between the facility and Relay Health Epremis that reports our data, as there were no errors reported this did come to light till the Certification Summary Report was run and at that point there was no opportunity to correct

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PROVIDER: Dell Childrens Medical Center

Outpatient Facility Comments, 1Q2015.txt

THCIC ID: 852000
QUARTER: 1
YEAR: 2015

Certified With Comments

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

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

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

PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
QUARTER: 1
YEAR: 2015

Certified With Comments

Files may contain duplicate and/or missing claims

PROVIDER: North Central Surgical Center
THCIC ID: 860600
QUARTER: 1
YEAR: 2015

Certified With Comments

Two cases submitted with errors. Patients from out of the country no valid zip code.

PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
QUARTER: 1
YEAR: 2015

Certified With Comments

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

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

PROVIDER: St Lukes Sugar Land Hospital

Outpatient Facility Comments, 1Q2015.txt

THCIC ID: 869700
QUARTER: 1
YEAR: 2015

Certified With Comments

The data reports for Quarter 1, 2015 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

Payer Source

A payer source mapping discrepancy has been identified. The HIS vendor is working towards a resolution.

PROVIDER: Abilene Surgery Center
THCIC ID: 900002
QUARTER: 1
YEAR: 2015

Certified With Comments

Approved by T. Y. to certify

PROVIDER: Round Rock Surgery Center
THCIC ID: 905000
QUARTER: 1
YEAR: 2015

Certified With Comments

Certifying data with duplicate claims. Please disregard duplicates.

PROVIDER: CHRISTUS Santa Rosa Physicians ASC New Braunfels
THCIC ID: 917000
QUARTER: 1
YEAR: 2015

Certified With Comments

2015 1st Q data

Outpatient Facility Comments, 1Q2015.txt

PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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

PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 1
YEAR: 2015

Certified with Comments

The data reports for Quarter 1, 2015 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

Payer Source

A payer source mapping discrepancy has been identified. The HIS vendor is working towards a resolution.

PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
QUARTER: 1
YEAR: 2015

Certified with Comments

Files may contain duplicate and/or missing claims

PROVIDER: Texas Health Harris Methodist Fort Worth Outpatient Surgery Center
THCIC ID: 970100
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification

database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

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PROVIDER: Texas Health Outpatient Surgery Center Alliance
THCIC ID: 970110
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

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

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular outpatient hospital stay are coded by the hospital using a universal standard called the International

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

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

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Outpatient Facility Comments, 1Q2015.txt

Cost/ Revenue Codes

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

PROVIDER: Dodson Surgery Center
THCIC ID: 970400
QUARTER: 1
YEAR: 2015

Certified with Comments

Cook Children's Medical Center has submitted and certified 1st QUARTER 2015 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 1st QUARTER OF 2015.

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: Huguley Surgery Center
THCIC ID: 971500
QUARTER: 1
YEAR: 2015

Certified with Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of December 1, 2015. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgments about patient care.

Submission Timing

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Diagnosis and Procedures

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

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using ICD-9-CM prior to 10-1-2015 and CPT. This is mandated by the federal government and all hospitals must comply.

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

There is no mechanism provided in the reporting process to factor in DNR (Do Not Resuscitate) patients. Any mortalities occurring to a DNR patient are not recognized separately; therefore mortality ratios may be accurate for reporting standards but overstated.

Given the current certification software, due to hospital volumes, it is not feasible to perform encounter level audits and edits. To meet the state's mandates to submit hospital Outpatient visits with specific procedures, Texas Health Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format.

The quarterly data to the best of our knowledge is accurate and complete given the above.

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PROVIDER: Baylor Medical Center McKinney
THCIC ID: 971900
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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

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

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

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

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PROVIDER: Texas Health Harris Methodist Hospital Alliance
THCIC ID: 972900
QUARTER: 1
YEAR: 2015

Certified with Comments

Data Content

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

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

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

Diagnosis and Procedures

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always

possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

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

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

Length of Stay

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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.

PROVIDER: Baylor Surgery Center of Waxahachie
THCIC ID: 973560
QUARTER: 1
YEAR: 2015

Certified with Comments

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

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

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

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

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

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PROVIDER: Saint Raphaels Surgery Center
THCIC ID: 973720
QUARTER: 1
YEAR: 2015

Certified with Comments

This data has not been reviewed. A new billing company contract has been initiated, effective October 1, 2015 (4th Qtr 2015), with the expectation that the error rate will be reduced to zero.

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PROVIDER: Walnut Hill Medical Center
THCIC ID: 973750
QUARTER: 1
YEAR: 2015

Certified with Comments

No comments

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PROVIDER: Parkway Surgical and Cardiovascular Hospital
THCIC ID: 973840
QUARTER: 1
YEAR: 2015

Certified with Comments

The data for 1Q2015 is being certified with comment. All reported data is accurate and correct at the specific point in time that the data files are generated. Information is subject to change after files are generated and submitted to THCIC; any changes would be information collected or updated during

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the normal course of business.

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PROVIDER: Forest Park Medical Center at San Antonio
THCIC ID: 974250
QUARTER: 1
YEAR: 2015

Certified with Comments

None.

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PROVIDER: Medical Center of Alliance
THCIC ID: 974490
QUARTER: 1
YEAR: 2015

Certified with Comments

Information is valid