General Comments on 3nd 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.

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PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
QUARTER: 3
YEAR: 2015

Certified With Comments

I elect to certify this data is accurate to the best of my knowledge as of this date of certification 02/17/2016.

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PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
QUARTER: 3
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.

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PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000

QUARTER: 3
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 cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Baylor Scott & White Medical Center-Garland
THCIC ID: 027000
QUARTER: 3
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: 3
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

cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Baylor Scott & White Medical Center Carrollton
THCIC ID: 042000
QUARTER: 3
YEAR: 2015

Certified With Comments

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

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PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
QUARTER: 3
YEAR: 2015

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of June 1, 2016. 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: CHI St Lukes Health Baylor College of Medicine Medical Center
THCIC ID: 118000
QUARTER: 3
YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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: University Medical Center
THCIC ID: 145000
QUARTER: 3
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: Coastal Bend Ambulatory Surgical Center
THCIC ID: 147001
QUARTER: 3
YEAR: 2015

Certified With Comments

Due to ICD 10 software updates in practice management system, all claim files did not upload properly for this quarter only.

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PROVIDER: JPS Surgical Center-Arlington
THCIC ID: 153300
QUARTER: 3
YEAR: 2015

Certified With Comments

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

JPSH is the only Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only psychiatric emergency center in the county. The hospital's services include intensive care for adults and newborns, an AIDS treatment center, a skilled nursing unit, a full range of obstetrical and gynecological
services, adult inpatient care and an inpatient mental health treatment facility.

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

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

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PROVIDER: Greenville Surgery Center

THCIC ID: 163000
QUARTER: 3
YEAR: 2015

Certified With Comments

Approved

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 3
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: The Heart Hospital Baylor Denton
THCIC ID: 208100
QUARTER: 3
YEAR: 2015

Certified With Comments

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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.

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PROVIDER: DeHaven Surgical Center
THCIC ID: 228002
 QUARTER: 3
    YEAR: 2015

Certified With Comments

submitted by Lisa Myers 10-26-15

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

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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.

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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: Wise Health System
THCIC ID: 254001
QUARTER: 3
YEAR: 2015

Certified With Comments

The data for 3Q2015 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: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
QUARTER: 3
YEAR: 2015

Certified With Comments

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PROVIDER: South Austin Surgery Center
THCIC ID: 262001
QUARTER: 3

YEAR: 2015

Certified With Comments

2015 Q3 Certification

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PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 3
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: South Plains Endoscopy Center
THCIC ID: 278000
QUARTER: 3
YEAR: 2015

Elected Not to Certify

We elect not to certify at this time.

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PROVIDER: Baylor Scott & White Medical Center Waxahachie
THCIC ID: 285000
QUARTER: 3
YEAR: 2015

Certified With Comments

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PROVIDER: Mother Frances Hospital
THCIC ID: 286000
 QUARTER: 3
    YEAR: 2015

Certified With Comments

Due to software error, approximately 1.6% of outpatient records were inadvertently omitted and are to be combined with 4Q submission.

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PROVIDER: Wilson N Jones Regional Medical Center
THCIC ID: 297000
 QUARTER: 3
    YEAR: 2015

Certified With Comments

Continue to work with vendor to reduce errors.

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PROVIDER: Baylor Scott & White Medical Center-Irving
THCIC ID: 300000
 QUARTER: 3
    YEAR: 2015

Certified With Comments

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PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 3
YEAR: 2015

Certified With Comments

THCIC ID:
TH303000
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Kaufman CERTIFIED WITH COMMENTS
Data Content
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hospital using a universal standard called the International Classification of Disease (ICD-9-CM)
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the guidelines for assigning these diagnosis codes; however, this is often driven by physician's
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situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to
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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.

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
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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
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payment value. These values
might not accurately reflect the hospital payer information, because those payers identified
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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
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of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care
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patient needs.

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 3
    YEAR: 2015

Certified With Comments

THCIC ID:
TH323000
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Cleburne 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
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that each
patient needs.

THCIC ID: 331000
QUARTER: 3
YEAR: 2015

Elected Not to Certify

Based on the reports pulled from THCIC (CO1 and CO4) vs.the clients validation, she did not feel they should certify. The number showed a large variation.

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PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 3
YEAR: 2015

Certified With Comments

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

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PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000
QUARTER: 3
YEAR: 2015

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: Medical Arts Hospital
THCIC ID: 341000
QUARTER: 3
YEAR: 2015

Elected Not to Certify

Due to the sheer volume of the data, we have limited resources as a hospital to analyze the data with 100% accuracy. We elect not to certify.

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PROVIDER: Baylor Scott & White All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 3
YEAR: 2015

Certified With Comments

PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 3
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: Muenster Memorial Hospital
THCIC ID: 365000
QUARTER: 3
YEAR: 2015

Certified With Comments

A small number of claims (approx <10) within this certification have been processed with errors.

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PROVIDER: Victoria Surgery Center
THCIC ID: 396003
QUARTER: 3
YEAR: 2015

Certified With Comments

All data reviewed and is correct.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 3
YEAR: 2015

Certified With Comments

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

JPSH is the only Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only psychiatric emergency center in the county. The hospital's services include intensive care for adults and newborns, an AIDS treatment center, a skilled nursing unit, a full range of obstetrical and gynecological
services, adult inpatient care and an inpatient mental health treatment facility.

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

podiatry and pharmacy. The family medicine residency is the largest hospital-based family medicine residency program in the nation.

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

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 3
YEAR: 2015

Certified With Comments

THCIC ID:
TH422000
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Arlington Memorial Hospital 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
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837 EDI electronic claim format. Then the state specifications require additional data elements to
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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)
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Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies
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the guidelines for assigning these diagnosis codes; however, this is often driven by physician's
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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.

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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

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Cost/ Revenue Codes
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patient needs.

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 3
    YEAR: 2015

Certified With Comments

THCIC ID:
TH431000
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Dallas CERTIFIED WITH COMMENTS
Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data
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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
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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
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PROVIDER: Mother Frances Hospital Winnsboro
THCIC ID: 446001
QUARTER: 3
YEAR: 2015

Certified With Comments

Due to software error, approximately 0.7% of outpatient records were inadvertently omitted and are to be combined with 4Q submission.

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PROVIDER: Dallas Medical Center
THCIC ID: 449000
QUARTER: 3
YEAR: 2015

Certified With Comments

Dallas Medical Center - 2015 3rd Quarter OP Certification

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PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
QUARTER: 3
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 Cardiac Program including Cardiothoracic Surgery and Interventional Cardiology as well as Electrophysiology; Accredited Chest Pain Center; a Bariatric Surgery Center of Excellence, Inpatient and Outpatient Rehabilitation Centers; Inpatient Adult Behavioral Health Center; Outpatient Counseling and Wellness Center, the DeTar Senior Care Center; Senior Circle; Primary Stroke Center and a free Physician Referral Call Center. To learn more, pleas e visit our website at www.detar.com.

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PROVIDER: DeTar Hospital-North
THCIC ID: 453001
QUARTER: 3
YEAR: 2015

Certified With Comments

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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 Cardiac Program including Cardiothoracic Surgery and Interventional Cardiology as well as Electrophysiology; Accredited Chest Pain Center; a Bariatric Surgery Center of Excellence, Inpatient and Outpatient Rehabilitation Centers; Inpatient Adult Behavioral Health Center; Outpatient Counseling and Wellness Center, the DeTar Senior Care Center; Senior Circle; Primary Stroke Center and a free Physician Referral Call Center. To learn more, pleas e visit our website at www.detar.com.

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PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
QUARTER: 3
YEAR: 2015

Certified With Comments

THCIC ID: TH469000
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Azle CERTIFIED WITH COMMENTS
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patient needs.

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PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 3
YEAR: 2015

Certified With Comments

PROVIDER: Parkland Memorial Hospital - Simmons Ambulatory Surgical Center
THCIC ID: 843300
QUARTER: 3
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 11, 059 staff. Approximately 1,347 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: 3
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.

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PROVIDER: Bellville St Joseph Health Center
THCIC ID: 552000
QUARTER: 3
YEAR: 2015

Certified With Comments

Certified by Karen McEuen

==========

PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
QUARTER: 3
YEAR: 2015

Certified With Comments

THCIC ID:
TH627000
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Southwest 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
04/20/16
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and ethnicity information. Therefore, depending on the circumstances of the patient's admission,
race and
ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not
provide an accurate representation of the patient population for a facility.

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

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

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 3
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.

==========
PROVIDER: Abilene Spine & Joint Surgery Center
THCIC ID: 711700
QUARTER: 3
YEAR: 2015

Certified With Comments

There are less claims for the month of September due to physicians on vacation.

==========
PROVIDER: CHRISTUS St Michael Rehab Hospital
THCIC ID: 713001
QUARTER: 3
YEAR: 2015

Certified With Comments

To the best of my knowledge, I certify this report.

==========
PROVIDER: Ennis Regional Medical Center
THCIC ID: 714500
QUARTER: 3
YEAR: 2015

Certified With Comments

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

==========

PROVIDER: Plastic & Cosmetic Surgery Center of Texas
THCIC ID: 715500
QUARTER: 3
YEAR: 2015

Certified With Comments

Aware there were errors in Quarter

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PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
QUARTER: 3
YEAR: 2015

Certified With Comments

As is.

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

THCIC ID: 725400
QUARTER: 3
YEAR: 2015

Certified With Comments

Due to software error, approximately 0.5% of outpatient records were inadvertently omitted and are to be combined with 4Q submission.

==========

PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
QUARTER: 3
YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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: CHRISTUS St Michael Health System
THCIC ID: 788001
QUARTER: 3
YEAR: 2015

Certified With Comments

To the best of my knowledge, I approve.

==========

PROVIDER: Christus St Michael Hospital Atlanta
THCIC ID: 788003
QUARTER: 3
YEAR: 2015

Certified With Comments

To the best of my knowledge, I approve.

==========

PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
QUARTER: 3
YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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: 3
YEAR: 2015

Certified With Comments

We investigated the Duplicate Events Summary Report and discovered that it was same day, same patient, two different procedures with two different doctors.

==========

PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
QUARTER: 3
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: 3
YEAR: 2015

Certified With Comments

Files may contain duplicate and/or missing claims

==========
PROVIDER: Baylor Scott & White Medical Center-Plano
THCIC ID: 814001
QUARTER: 3
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.

==========
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
QUARTER: 3
YEAR: 2015

Certified With Comments

Files may contain duplicate and/or missing claims

==========
PROVIDER: Spinecare
THCIC ID: 816900
QUARTER: 3
YEAR: 2015

Elected Not to Certify

DATA IS GENERATED FROM FACILITY'S SCHEDULING SOFTWARE. WE CANNOT GUARANTEE 100% ACCURACY.

==========
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 3
YEAR: 2015

Certified With Comments

THCIC ID:
TH820800
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Denton 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
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hospital using a universal standard called the International Classification of Disease (ICD-9-CM)
and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The hospital complies
with
the guidelines for assigning these diagnosis codes; however, this is often driven by physician's
subjective criteria for defining a diagnosis. For example, while one physician may diagnose a
patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician
may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both
situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to
determine that diagnosis was different. An apples to apples comparison cannot be made, which
makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

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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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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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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
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and ethnicity information. Therefore, depending on the circumstances of the patient's admission,
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ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not
provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment
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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: Park Hudson Surgery Center
THCIC ID: 824400
 QUARTER: 3
    YEAR: 2015

Certified With Comments

The data submitted in this quarter contains 2nd quarter data.

==========
PROVIDER: Memorial Hermann Surgery Center Woodlands
THCIC ID: 825400
 QUARTER: 3
    YEAR: 2015

Certified With Comments

No comments

==========
PROVIDER: Dallas Endoscopy Center
THCIC ID: 826200
 QUARTER: 3
    YEAR: 2015

Certified With Comments

UPON SPOT CHECKING A FEW CLAIMS IT ALL APPEARS TO LOOK ACCURATE

==========
PROVIDER: Pampa Regional Medical Center
THCIC ID: 832900
 QUARTER: 3
    YEAR: 2015

Certified With Comments

Pampa Regional Medical Center - 2015 3rd Quarter OP Certification

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PROVIDER: American Surgery Centers of South Texas
THCIC ID: 835200
QUARTER: 3
YEAR: 2015

Certified With Comments

regenerated corrected report for the 3rd quarter 2015

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PROVIDER: Southwest Endoscopy & Surgery Center
THCIC ID: 836400
QUARTER: 3
YEAR: 2015

Certified With Comments

The data is true and accurate to my knowledge and is certified 3/9/2016

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PROVIDER: Simmons Ambulatory Surgery Center
THCIC ID: 843300
QUARTER: 3
YEAR: 2015

Certified With Comments

PROVIDER: Parkland Memorial Hospital - Simmons Ambulatory Surgical Center
THCIC ID: 843300
QUARTER: 3
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 11, 059 staff. Approximately 1,347 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: Heart Hospital Baylor Plano
THCIC ID: 844000
QUARTER: 3
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.

==========

PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
QUARTER: 3
YEAR: 2015

Certified With Comments

Files may contain duplicate and/or missing claims

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PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
QUARTER: 3
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
THCIC ID: 869700
QUARTER: 3

YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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: 3
YEAR: 2015

Certified With Comments

Certify as presented

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PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 3
YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
QUARTER: 3
YEAR: 2015

Certified With Comments

Files may contain duplicate and/or missing claims

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PROVIDER: Beltline Surgery Center
THCIC ID: 948000
QUARTER: 3
YEAR: 2015

Certified With Comments

This is Q3 2015 data previously submitted being resubmitted in ICD 9 format.

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PROVIDER: Texas Health Harris Methodist Fort Worth Outpatient Surgery Center
THCIC ID: 970100
QUARTER: 3
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: 3
YEAR: 2015

Certified With Comments

THCIC ID:
TH970110
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Alliance Outpatient Surgery Center 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
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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: Dodson Surgery Center
THCIC ID: 970400
 QUARTER: 3
    YEAR: 2015

Certified With Comments

Cook Children's Medical Center has submitted and certified 3RD 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 3RD 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.

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PROVIDER: Huguley Surgery Center
THCIC ID: 971500
QUARTER: 3
YEAR: 2015

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of June 1, 2016. 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 Scott & White Medical Center McKinney
THCIC ID: 971900
QUARTER: 3
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: 3
YEAR: 2015

Certified With Comments

THCIC ID:
TH972900
QUARTER: 2015 Quarter 3 Outpatient
Texas Health Alliance CERTIFIED WITH COMMENTS
Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data
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The state requires us to submit outpatient claims for patients that receive outpatient surgical or
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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.

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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
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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: Executive Surgery Center
THCIC ID: 973480
 QUARTER: 3
    YEAR: 2015

Certified With Comments

We changed EHR providers 9/15/15. The new provider has not correctly generated required report format to upload case information. There are 93 cases from 9/15-9/30 that are not in this report. I am working daily with IT to get report formatted and uploaded. Will upload additional case datea as soon as it is available.

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PROVIDER: Baylor Surgery Center of Waxahachie
THCIC ID: 973560
 QUARTER: 3
    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: Parkway Surgical and Cardiovascular Hospital
THCIC ID: 973840
 QUARTER: 3
    YEAR: 2015

Certified With Comments

The data for 3Q2015 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: Resolute Health
THCIC ID: 973850
QUARTER: 3
YEAR: 2015

Certified With Comments

Includes Q2

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PROVIDER: Baylor Heart and Vascular Hospital of Fort Worth
THCIC ID: 974240
QUARTER: 3
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: Planned Parenthood South Texas Surgical Center
THCIC ID: 974780
QUARTER: 3
YEAR: 2015

Certified With Comments

Data was Inadvertently submitted without the physician name.

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PROVIDER: Baylor St Lukes Medical Center McNair Endoscopy
THCIC ID: 974790
QUARTER: 3
YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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: CHI St Lukes Health Baylor Medical Center ASC
THCIC ID: 974960
QUARTER: 3
YEAR: 2015

Certified With Comments

The data reports for Quarter 3, 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.