General Comments on 3rd Quarter 2014 Data

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

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

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

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

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

·        The Source of Admission data element is suppressed if the Type of Admission field indicates the patient is newborn. The condition of the newborn can be determined from the diagnosis codes. Source of admission for newborns is suppressed indefinitely.

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

===============================================================================
PROVIDER: Austin State Hospital
THCIC ID: 000100
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Known issues with NPIs


===============================================================================
PROVIDER: Big Spring State Hospital
THCIC ID: 000101
 QUARTER: 3
    YEAR: 2014

Certified With Comments

known NPI issues


===============================================================================

PROVIDER: Rio Grande State Center
THCIC ID: 000104
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Known issues with Dr NPIs


================================================================================
PROVIDER: UT MD Anderson Cancer Center
THCIC ID: 000105
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Due to system and technical limitations, some claims were submitted without
diagnosis/procedure codes prior to being prepared for submission.  The claims
are not submitted to payors until the claims are coded.


================================================================================
PROVIDER: Kerrville State Hospital
THCIC ID: 000106
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Known NPI issues


================================================================================
PROVIDER: Rusk State Hospital
THCIC ID: 000107
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Known NPI issues


================================================================================
PROVIDER: San Antonio State Hospital
THCIC ID: 000110
 QUARTER: 3
    YEAR: 2014

Certified With Comments

known NPI issues


================================================================================
PROVIDER: Terrell State Hospital
THCIC ID: 000111
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Known NPI issues


===============================================================================
PROVIDER: North Texas State Hospital-Vernon
THCIC ID: 000113
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Problems with NPI #'s, but has not been corrected


===============================================================================
PROVIDER: North Texas State Hospital
THCIC ID: 000114
 QUARTER: 3
    YEAR: 2014

Certified With Comments

known issues with NPIs


===============================================================================
PROVIDER: Waco Center for Youth
THCIC ID: 000117
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Known issues with Dr NPIs


===============================================================================
PROVIDER: El Paso Psychiatric Center
THCIC ID: 000118
 QUARTER: 3
    YEAR: 2014

Certified With Comments

known issues with NPIs


===============================================================================
PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

I elect to certify this data is accurate to the best of my knowledge, as of this
date, 02/09/2015, of certification.


===============================================================================
PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000

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   QUARTER: 3
      YEAR: 2014
```

Certified With Comments

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


```
===============================================================================
PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006001
 QUARTER: 3
      YEAR: 2014
```

Certified With Comments

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


```
===============================================================================
PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
 QUARTER: 3
      YEAR: 2014
```

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: Good Shepherd Medical Center
THCIC ID: 029000
 QUARTER: 3
      YEAR: 2014
```

Certified With Comments

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


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===============================================================================
PROVIDER: Baylor Medical Center at Carrollton
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THCIC ID: 042000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

PROVIDER: Baylor Medical Center Carrollton
THCIC ID: 042000
QUARTER: 3
YEAR: 2014

Certified with comments

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

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

The THCIC minimum data set houses only two (2) physician fields; Attending
Physician and Operating or Other Physician (if applicable) as reflected
on the UB92 billing document.  Mortality rates, case costs and other data
calculated for this population of physicians may be misrepresentative.
Due to the complexity of most inpatient admissions many physicians provide
care to patients throughout an admission.  Consulting physicians may prescribe
and treat patients on behalf of the physician listed as the attending
physician.  Analysis of this physician information should carefully consider
that significant variations in case count, case cost, and mortality may
not be directly related to the care provided by the attending physician,
but also reflect the varied use of consultants.

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

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

The codes are assigned based on documentation in the patient's chart and
are used by hospitals for billing purposes.  The hospital can code as
many as 25 diagnoses and 25 procedures for each patient record.  One limitation
of using the ICD-9-CM system is that there does not exist a code for every

possible diagnosis and procedure due to the continued evolution of medicine;
new codes are added yearly as coding manuals are updated.

Normal Newborns
The best way to focus on severity of illness regarding an infant would
be to check the infant's diagnosis at discharge, not the admitting source
code. The actual experience of a newborn is captured elsewhere in the
file, namely, in the ICD-9-CM diagnosis. Admission source does not give
an accurate picture.

Mortalities
Due to insurance payer requirements, organ donor patients are readmitted
and expired in the system to address the issues of separate payers.  This
results in double counting some "expired" cases which will increase the
mortality figure reported and not accurately reflect the actual number
of mortalities.

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

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

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

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

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

================================================================================
PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of July 2, 2015.  Due to a
processing issue during the encounter/event build, the state re-built the
certification data set. The changes were due to Other Procedure codes that were
not passed from the claims to the certification data set.  The missing Other
Procedure codes can have an effect on the DRG assignments.  This certification
quarter Inpatient file is being re-certified.  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 no billed by this cut-off date will not be
included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient.  In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed which can alter the true picture of a patient's
hospitalization, sometimes significantly.
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a ICD-9-CM.  This is mandated by the federal government and all
hospitals must comply.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes.  The hospital can code as many as 25
diagnoses and 25 procedures for each patient record.  One limitation of using
the ICD-9-CM is that there does not exist a code for every possible diagnosis
and procedure due to the continued evolution of medicine; new codes are added
yearly as coding manuals are updated.
There is no mechanism provided in the reporting process to factor in DNR (Do Not
Resuscitate) patients.  Any mortalities occurring to a DNR patient are not
recognized separately; therefore mortality ratios may be accurate for reporting
standards but overstated.
Physician
While the hospital documents many treating physicians for each case, the THCIC
minimum data set has only (2) physician fields, Attending and Operating
Physicians.  Many physicians provide care to patients throughout a hospital
stay.  Consulting physicians may prescribe and treat patients on behalf of the
physician listed as the Attending.  "Other" physician case volumes, mortality,
case costs and LOS, will frequently be inaccurate because of this limitation.
Analysis of "Other physician" information should, therefore, take into
consideration that a significant portion of treating physicians are excluded
from the patient cases.
Given the current certification software, there is not an efficient mechanism to
edit and correct the data.  In addition, due to hospital volumes, it is not
feasible to perform encounter level audits and edits.  All known errors have
been corrected to the best of our knowledge.  Within the constraints of the
current THCIC process, the data is certified to the best of our knowledge as
accurate and complete given the above comments.


================================================================================
PROVIDER: San Angelo Community Medical Center
THCIC ID: 056000
 QUARTER: 3
    YEAR: 2014

Elected Not to Certify

elect to not certify


===============================================================================
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data reports for Quarter 3, 2014 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: University Medical Center
THCIC ID: 145000
 QUARTER: 3
    YEAR: 2014

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.


===============================================================================
PROVIDER: TIRR Memorial Hermann
THCIC ID: 164000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

No Comments.


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

YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

patients, are likewise less accurately reflected.

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

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

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

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

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

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

================================================================================
PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000

QUARTER: 3
  YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

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

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

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

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

================================================================================
PROVIDER: Wise Regional Health System

THCIC ID: 254000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data for 3Q2014 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.


===============================================================================
PROVIDER: Wise Regional Health System
THCIC ID: 254001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data for 3Q2014 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.


===============================================================================
PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular hospital stay are coded by the
hospital using a universal standard called the International Classification of
Disease, or ICD 9 CM.  This is mandated by the federal government.  The hospital
complies with the guidelines for assigning these diagnosis codes, however, this
is often driven by physician's subjective criteria for defining a diagnosis.
For example, while one physician may diagnose a patient with anemia when the
patient's blood hemoglobin level falls below 9.5, another physician may not
diagnose the patient with anemia until their blood hemoglobin level is below

9.0.  In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different.  An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.

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

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

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

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

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

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

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

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

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

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


===============================================================================
PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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


===============================================================================
PROVIDER: Wilson N Jones Regional Medical Center
THCIC ID: 297000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Continue to work with vendor to reduce errors.


===============================================================================
PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000

QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

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

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

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

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

================================================================================

THCIC ID: 323000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

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

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

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

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

================================================================================

PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

After the correction of the data, BUMC has chosen to certify.

PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 3
YEAR: 2014

Certified with comments

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

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

The THCIC minimum data set houses only two (2) physician fields; Attending
Physician and Operating or Other Physician (if applicable) as reflected
on the UB92 billing document.  Mortality rates, case costs and other data
calculated for this population of physicians may be misrepresentative.
Due to the complexity of most inpatient admissions many physicians provide
care to patients throughout an admission.  Consulting physicians may prescribe
and treat patients on behalf of the physician listed as the attending
physician.  Analysis of this physician information should carefully consider
that significant variations in case count, case cost, and mortality may
not be directly related to the care provided by the attending physician,
but also reflect the varied use of consultants.

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

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

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

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

Normal Newborns
The best way to focus on severity of illness regarding an infant would
be to check the infant's diagnosis at discharge, not the admitting source
code. The actual experience of a newborn is captured elsewhere in the
file, namely, in the ICD-9-CM diagnosis. Admission source does not give
an accurate picture.

Mortalities
Due to insurance payer requirements, organ donor patients are readmitted
and expired in the system to address the issues of separate payers.  This
results in double counting some "expired" cases which will increase the
mortality figure reported and not accurately reflect the actual number
of mortalities.

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

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

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

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

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

===============================================================================
PROVIDER: Cook Childrens Medical Center

THCIC ID: 332000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Cook Children's Medical Center has submitted and certified 3rd QUARTER
2014 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 2014.

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

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

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


===============================================================================
PROVIDER: Denton Regional Medical Center
THCIC ID: 336001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Information Valid


===============================================================================
PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 3
YEAR: 2014

Certified with comments

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

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

The THCIC minimum data set houses only two (2) physician fields; Attending
Physician and Operating or Other Physician (if applicable) as reflected
on the UB92 billing document.  Mortality rates, case costs and other data
calculated for this population of physicians may be misrepresentative.
Due to the complexity of most inpatient admissions many physicians provide
care to patients throughout an admission.  Consulting physicians may prescribe
and treat patients on behalf of the physician listed as the attending
physician.  Analysis of this physician information should carefully consider
that significant variations in case count, case cost, and mortality may
not be directly related to the care provided by the attending physician,
but also reflect the varied use of consultants.

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

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

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

Medical Record Number

Due to a new system implementation, the Medical Record format was changed from
alphanumeric to numeric.  Starting 4QTR2004 forward, the leading digit of M was
dropped leaving the remaining number as the Medical Record number.  This change
in format will need to be considered when calculating any readmission rates or
the rates will be erroneously lower.
Race/Ethnicity
There are no national standards regarding patient race categorization
so hospitals may not have the same designations from which patients can
choose.  The state has recently attempted to standardize a valid set of
race codes for this project but these are not universally used by all
hospitals.  Each hospital must independently map their specific codes
to the state's race code categories.  This mapping may not be consistent
across hospitals. Thus epidemiology analysis of these two data fields
does not accurately describe the true population served by the hospital.


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

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

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

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


================================================================================
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

services, inpatient care for patients of all ages and an inpatient mental
health treatment facility.

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

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


===============================================================================
PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the

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

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

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

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

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

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

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

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


================================================================================
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes.  The hospital can code up to 99
diagnoses and 99 procedures for each patient record.  The state is requiring us
to submit ICD-9-CM data on each patient but has limited the number of diagnoses
and procedures to the first 25 diagnoses codes and the first 25 procedure codes.
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severity of illness category). It would be obvious; therefore, those sicker
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Length of Stay
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Admit Source data for Normal Newborn
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whether the baby was a normal newborn, premature delivery, sick baby, extramural
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illness regarding an infant would be to check the infant's diagnosis at
discharge, not the admitting source code. Many hospital information systems and
registration process defaults to normal delivery as the admission source.
Therefore, admission source does not always give an accurate picture.

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

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

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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.
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===============================================================================
PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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


===============================================================================
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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will ensure correct identification of the clinical status of the newborn
admission.

Race/Ethnicity
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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
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===============================================================================
PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based
health centers and Parkland Memorial Hospital, which was established in
1894.  The Parkland System is a $995 million enterprise that is licensed
for 968 beds and employs approximately 10,126 staff.  12,127 adult patients
received inpatient care this quarter.  The hospital delivered over 10,100
newborns during the 12 month period ending September 2014.

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: Baylor Regional Medical Center-Grapevine
THCIC ID: 513000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Inpatient looks good.
Olga Young, CHFP
Financial Analyst II
Baylor Regional Medical Center at Grapevine


================================================================================
PROVIDER: Bellville St Joseph Health Center
THCIC ID: 552000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Certified by Karen McEuen


================================================================================
PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Data Content
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9.0.  In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different.  An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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Race/Ethnicity
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===========================================================================
PROVIDER: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Data Content
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Admit Source data for Normal Newborn
Texas Health Specialty Hospital does not have a newborn population.

Race/Ethnicity
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===============================================================================
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

obtain accurate information regarding things such as complication rates.

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

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

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

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

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

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record.  In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment

value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO.  Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

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

Discharge Disposition
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================================================================================
PROVIDER: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Results may not be 100% accurate.


================================================================================
PROVIDER: CHRISTUS Dubuis Hospital-Beaumont
THCIC ID: 708000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital.  This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems.  Subsequently they require a longer hospital stay than the younger population.


================================================================================
PROVIDER: CHRISTUS Dubuis Hospital-Port Arthur
THCIC ID: 708001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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==============================================================================
PROVIDER: Red River Hospital
THCIC ID: 709001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

3q.2014


==============================================================================
PROVIDER: Our Childrens House Baylor
THCIC ID: 710000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The OCH IP Discharges totals are only 1 different than what I count.  The distribution mix by charges, admission type, point of origin, discharge status, DRGs, procedures, demographics, etc all appear reasonable.


==============================================================================
PROVIDER: Texas Health Seay Behavioral Health Center
THCIC ID: 720000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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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
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registration process defaults to normal delivery as the admission source.
Therefore, admission source does not always give an accurate picture.

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This methodology will ensure correct identification of the clinical status of
the newborn admission.

Race/Ethnicity
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Discharge Disposition
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and the plan to address this issue in writing to the THCIC Executive Director.


==============================================================================
PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Data Content
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Diagnosis and Procedures

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

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and the plan to address this issue in writing to the THCIC Executive Director.


===============================================================================
PROVIDER: El Paso Specialty Hospital
THCIC ID: 728200
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Omar Garza, CFO is certifying this data.


===============================================================================
PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

THHV - Inpatient

Data Content
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================================================================================
PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
 QUARTER: 3
    YEAR: 2014


Certified With Comments

The data reports for Quarter 3, 2014 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

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


================================================================================
PROVIDER: Texas Health Springwood Hospital
THCIC ID: 778000
 QUARTER: 3
    YEAR: 2014

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facility.

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

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

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


===============================================================================
PROVIDER: Dubuis Hospital-Paris
THCIC ID: 787500
 QUARTER: 3

     YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital.  This designation of Long
Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many
aspects. Therefore relevant comparisons should be made with only other Long Term
Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately
25 days are admitted to Dubuis Hospital per our designation as Long Term Acute.
Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have
more serious illnesses with more frequent secondary problems.  Subsequently they
require a longer hospital stay than the younger population.


===============================================================================
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Certified to the best of my knowledge.


===============================================================================
PROVIDER: Christus St Michael Hospital Atlanta
THCIC ID: 788003
 QUARTER: 3
    YEAR: 2014

Certified With Comments

To the best of my knowledge.


===============================================================================
PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data reports for Quarter 3, 2014 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: Dubuis Hospital-Corpus Christi
THCIC ID: 797001
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital.  This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems.  Subsequently they require a longer hospital stay than the younger population.


==============================================================================
PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The file may contain duplicate or missing claims


==============================================================================
PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
 QUARTER: 3
    YEAR: 2014

Certified With Comments

This file may contain duplicate or missing claims


==============================================================================
PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

* accouts has no SSN#

*THCIC removed potential confidential information from this comment.

================================================================================
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The file may contain duplicate or missing claims


================================================================================
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient.  In other words, the state's data

file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.

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

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

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

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

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

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

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

===============================================================================
PROVIDER: Dubuis Hospital-Texarkana
THCIC ID: 822000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital.  This designation of Long
Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many
aspects. Therefore relevant comparisons should be made with only other Long Term
Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately
25 days are admitted to Dubuis Hospital per our designation as Long Term Acute.
Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have
more serious illnesses with more frequent secondary problems.  Subsequently they
require a longer hospital stay than the younger population.

===============================================================================
PROVIDER: Integrity Transitional Hospital
THCIC ID: 844200
 QUARTER: 3
    YEAR: 2014

Certified With Comments

3rd Quarter was not certified due to duplicate data and data set

===============================================================================
PROVIDER: Dubuis Hospital-Texarkana-Wadley
THCIC ID: 847600
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital.  This designation of Long
Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many
aspects. Therefore relevant comparisons should be made with only other Long Term
Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately
25 days are admitted to Dubuis Hospital per our designation as Long Term Acute.
Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems.  Subsequently they require a longer hospital stay than the younger population.


===============================================================================
PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
 QUARTER: 3
    YEAR: 2014

Certified With Comments

This file may contain duplicates or missing claims


===============================================================================
PROVIDER: Kate Dishman Rehab Hospital
THCIC ID: 861900
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Please note that the data reported under the claim filing indicator code appears to be incorrect.  The report list zero (0) Medicare claims.  During the quarter we had 85 Medicare fee for service claims and 5 Medicare managed care claims.


===============================================================================
PROVIDER: CHRISTUS Dubuis Hospital-Bryan
THCIC ID: 864800
 QUARTER: 3
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital.  This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems.  Subsequently they require a longer hospital stay than the younger population.


===============================================================================
PROVIDER: TrustPoint Hospital
THCIC ID: 865800
 QUARTER: 3
    YEAR: 2014

Elected Not to Certify

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

================================================================================
PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data reports for Quarter 3, 2014 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: St Lukes Lakeside Hospital
THCIC ID: 923000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data reports for Quarter 3, 2014 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

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


================================================================================

PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
 QUARTER: 3
    YEAR: 2014

Certified With Comments

This file may contain duplicates or missing claims


===============================================================================
PROVIDER: Texas Health Harris Methodist Hospital Alliance
THCIC ID: 972900
 QUARTER: 3
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

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

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

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

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

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received

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

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


========================================================================
PROVIDER: Parkway Surgical and Cardiovascular Hospital
THCIC ID: 973840
 QUARTER: 3
    YEAR: 2014

Certified With Comments

The data for 3Q2014 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.