General Comments on 1st Quarter 2012 Data

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

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

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

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

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

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

===
PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
 QUARTER: 1
    YEAR: 2012

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 8,804 staff. 85,936 patients received outpatient care in the
clinics (both on campus and in the neighborhood-based health centers) this quarter.

Specific Data Concerns

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

==
PROVIDER: St Joseph Regional Health Center
THCIC ID: 002001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

St Joseph Regional Health Center uses TX 2400 format to do outpatient data
submission through its vendor Truven Health (http://truvenhealth.com/), formerly
Thomson Reuters.

Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. St Joseph Regional Health Center
submits more than required outpatient discharges to Truven Health, who then
converts the submitted outpatient records to 837 format and sends all submitted
outpatient records to THCIC data warehouse System 13 Inc
(https://thcic.system13.com). Unwanted outpatient records, defined as those
records containing non reportable revenue codes, are dropped by System 13, Inc.

On Oct 19th 2012, St Joseph Regional Health Center was notified by Truven Health
with the following statement:

" Truven Health has been notified that records with a 320 revenue code for your
OP data submission have been excluded from the extracts Truven Health sends to
System 13 beginning with Jan 1, 2012 data. "

Although Truven Health did a resubmission of Q1 2012 outpatient data, it may
contain fewer records than actually occurred. User discretion is advised in
using outpatient data for analysis purposes.

==
PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

==
PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

```
================================================================================
```
PROVIDER: Yoakum Community Hospital
THCIC ID: 023000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Patient Ethnicity is incorrect. We have majority hispanic. This was a HMS
issue that is now been corrected. The data is not reflected in this report.


```
================================================================================
```
PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

```
================================================================================
```
PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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


```
================================================================================
```

PROVIDER: Madison St Joseph Health Center
THCIC ID: 041000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Madison St. Joseph Hospital uses TX 2400 format to do outpatient data submission
through its vendor Truven Health (http://truvenhealth.com/), formerly Thomson
Reuters.

Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. Madison St. Joseph Hospital submits
more than required outpatient discharges to Truven Health, who then converts the
submitted outpatient records to 837 format and sends all submitted outpatient
records to THCIC data warehouse System 13 Inc (https://thcic.system13.com).
Unwanted outpatient records, defined as those records containing
non reportable revenue codes, are dropped by System 13, Inc.

On Oct 19th 2012, Madison St. Joseph Hospital was notified by Truven Health with
the following statement:
"Truven Health has been notified that records with a 320 revenue code for your
OP data submission have been excluded from the extracts Truven Health sends to
System 13 beginning with Jan 1, 2012 data. "

Although Truven Health did a resubmission of Q1 2012 outpatient data, it may
contain fewer records than actually occurred. User discretion is advised in
using outpatient data for analysis purposes.

==
PROVIDER: Baylor Medical Center at Carrollton
THCIC ID: 042000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Baylor Medical Center Carrollton OUTPATIENT DATA
THCIC ID: 042000
QUARTER: 1
YEAR: 2012

CERTIFIED WITH COMMENTS

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

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

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

Patients and physicians consider many factors when making health care decisions

Outpatient Facility Comments, 1Q2012.txt
that are not available in administrative data. These include a patients
preference for life-sustaining treatments, functional status, and other factors.

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

==
PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
 QUARTER: 1
    YEAR: 2012

Elected Not to Certify

Due to the notification from THCIC, October 29, 2012 the THCIC Outpatient
Technical Specification Manual was previously incorrect and specific revenue
codes were unintentionally omitted from the manual, the Huguley Memorial
Medical Center Outpatient dataset is incomplete at the time of Certification.
THCIC plans to merge the "missing" patient encounters back into the 1st quarter
dataset with a future quarterly dataset but due to constraints with THCIC
deadlines, the hospital is unable to verify this process.

The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of December 3, 2012. If any
errors are discovered in our data after this point, we will be unable to
communicate these due to THCIC. This data is administrative data, which
hospitals collect for billing purposes, and not clinical data, from which you
can make judgments about patient care.

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

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

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

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

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

Physician

While the hospital documents many treating physicians for each case, the THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians. Many physicians provide care to patients throughout a hospital stay. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Analysis of "Other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. To meet the state's mandates to submit hospital Outpatient visits with specific procedures, Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format. All known errors have been corrected to the best of our knowledge.

==
PROVIDER: Covenant Medical Center-Lakeside
THCIC ID: 109000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Missing claims: Revenue code 0320 omitted.

==
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

==
PROVIDER: Memorial Hermann Southeast Hospital
THCIC ID: 119000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012 submission are patients who incurred, in addition to Revenue Code 0320, another one of the THCIC required Revenue Codes.

==
PROVIDER: Providence Memorial Hospital
THCIC ID: 130000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

THCIC Certification Summary for the 1st Quarter 2012 Outpatient reflects a higher "Event" count as of January 2012, as compared to previous quarters since the "Event" count now includes Outpatient visits from our eastside clinic.

==
PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

==
PROVIDER: TIRR Memorial Hermann
THCIC ID: 164000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012 submission are patients who incurred, in addition to Revenue Code 0320, another one of the THCIC required Revenue Codes.

==
PROVIDER: Memorial Hermann Northwest Hospital
THCIC ID: 172000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012 submission are patients who incurred, in addition to Revenue Code 0320, another one of the THCIC required Revenue Codes.

==
PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-9-CM / CPT data on each outpatient receiving surgical or
radiological services, but has limited the number of diagnoses and procedures to
the first 25 diagnoses codes and the first 25 procedure codes. As a result, the

data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

===
PROVIDER: Medical Center-Plano
THCIC ID: 214000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

===
PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely

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

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

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

==
PROVIDER: Wise Regional Health System
THCIC ID: 254001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Data is a "snapshot" of information status available at time of certification.

==
PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

than 1% of the encounter volume.

Upon review of the Q1 data, it was discovered that 47 cases that were performed at the surgery center were submitted with the hospitals data submission. The cause of the discrepancy is being addressed and corrected.

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

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

==
PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
 QUARTER: 1
    YEAR: 2012

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.

The newborn data is being reported as Born in Hospital and Born outside Hospital which includes our well, premature and sick babies.

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

==
PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

```
===============================================================================
```
PROVIDER: Mother Frances Hospital
THCIC ID: 286000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Due to vendor error, approximately 0.3% of records are missing.

```
===============================================================================
```
PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

```
===============================================================================
```
PROVIDER: Memorial Hermann Memorial City Medical Center
THCIC ID: 302000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another
one of the THCIC required Revenue Codes.

==
PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

===
PROVIDER: Covenant Hospital-Levelland
THCIC ID: 307000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Revenue code 0320 claims are missing this quarter.

===
PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

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

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

database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

===
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Baylor Medical Center at BUMC
OUTPATIENT DATA
THCIC ID: 331000
QUARTER: 1
YEAR: 2012

CERTIFIED WITH COMMENTS

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

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

We recommend the Patient communicate with the Hospital and the Physician regarding data.
Patient and physician preference contributes to the care rendered to the patient

and the data does not always reflect this.

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

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

==
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Cook Children's Medical Center has submitted and certified 1st QUARTER
2012 inpatient, outpatient surgery and outpatient radiology encounters to
the Texas Health Care Information Council with the following possible data
concerns based on the required submission method.

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

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

Comparative complication reports reflecting the above conditions could
misstate the true conditions at Cook Children's Medical Center for the
1st QUARTER OF 2012.

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

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

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

==
PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000

    QUARTER: 1
       YEAR: 2012

Certified With Comments

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

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

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

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

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

==
PROVIDER: Denton Regional Medical Center
THCIC ID: 336001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: Memorial Hermann Hospital
THCIC ID: 347000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another

one of the THCIC required Revenue Codes.

==
PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 1
    YEAR: 2012

Elected Not to Certify

Q1 Outpatient data was inaccurate due to THCIC Outpatient Technical Specs which
include Revenue Code 0320, Radiology, Diagnostic General Classification, which
was unintentionally omitted when updating the manual. Claims were resubmitted
and accepted; however, not processed in time to reflect on Certification
Reports. Due to discrepancy of the Certification Reports and revenue counts,
ASFW has decided not to certify.

==
PROVIDER: Baylor Medical Center-Southwest Fort Worth
THCIC ID: 363001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Baylor Medical Center at SWFW OUTPATIENT DATA
THCIC ID: 363001
QUARTER: 1
YEAR: 2012

CERTIFIED WITH COMMENTS

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

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

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

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

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

==
PROVIDER: Medical Center-Lewisville

THCIC ID: 394000
 QUARTER: 1
     YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: Memorial Hermann Southwest Hospital
THCIC ID: 407000
 QUARTER: 1
     YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another
one of the THCIC required Revenue Codes.

==
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 1
     YEAR: 2012

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: 1
     YEAR: 2012

Certified With Comments

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

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

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

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

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

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

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

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

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

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

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

==
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD 9 CM) and Current Procedural Terminology Codes

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

Cost/ Revenue Codes

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

==
PROVIDER: North Hills Hospital
THCIC ID: 437000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: UT Southwestern University Hospital-St Paul
THCIC ID: 448001
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Data Source
The data included in this file is submitted in an effort to meet statutory requirements.   Data should be cautiously used to evaluate health care quality and compare outcomes.
Physicians
All physicians names and license numbers have been validated as accurate pursuant to the physicians reference file from the Texas Board of Medical Examiners.   Some physician may remain unidentified in the THCIC Practitioner Reference Files as a result of the delay in state license number assignment.
Costs and Charges
The state requires that we submit revenue information including charges.   It is important to note that charges do not reflect actual reimbursement received, nor do they reflect actual cost of providing services.

==
PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

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

===
PROVIDER: DeTar Hospital-North
THCIC ID: 453001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

===
PROVIDER: Covenant Medical Center
THCIC ID: 465000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Missing claims: Revenue code 0320 claims omitted.

===
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

==
PROVIDER: Plaza Medical Center-Fort Worth
THCIC ID: 477000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: Nacogdoches Memorial Hospital
THCIC ID: 478000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Please note: I did not prepare the data related to Q1.   Clarice Guy no longer
works at the facility.   Certifier Name is in the process of being updated.   Jane
Ann Bridges, CFO

==
PROVIDER: Seton Medical Center
THCIC ID: 497000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

==
PROVIDER: Medical Center-Arlington
THCIC ID: 502000

     QUARTER: 1
        YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: Baylor Regional Medical Center-Grapevine
THCIC ID: 513000
  QUARTER: 1
     YEAR: 2012

Elected Not to Certify

Q1 Outpatient data was inaccurate due to THCIC Outpatient Technical Specs which
include Revenue Code 0320, Radiology, Diagnostic General Classification, which
was unintentionally omitted when updating the manual. Claims were resubmitted
and accepted; however, not processed in time to reflect on Certification
Reports. Due to discrepancy of the Certification Reports and revenue counts,
Grapevine has decided not to certify.

==
PROVIDER: Memorial Hermann Katy Hospital
THCIC ID: 534001
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another
one of the THCIC required Revenue Codes.

==
PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

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

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

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

requirements.

==
PROVIDER: Memorial Hermann Sugar Land
THCIC ID: 609001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another
one of the THCIC required Revenue Codes.

==
PROVIDER: Memorial Hermann The Woodlands Hospital
THCIC ID: 615000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another
one of the THCIC required Revenue Codes.

==
PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

==
PROVIDER: UT Southwestern University Hospital-Zale Lipshy
THCIC ID: 653001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Data Source
The data included in this file is submitted in an effort to meet statutory
requirements. Data should be cautiously used to evaluate health care quality
and compare outcomes.
Physicians
All physicians names and license numbers have been validated as accurate
pursuant to the physicians reference file from the Texas Board of Medical
Examiners. Some physician may remain unidentified in the THCIC Practitioner
Reference Files as a result of the delay in state license number assignment.
Costs and Charges
The state requires that we submit revenue information including charges. It is
important to note that charges do not reflect actual reimbursement received, nor
do they reflect actual cost of providing services.

==
PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Some outpatients with revenue code 320 are missing.

==
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological services, by quarter year, gathered from a
form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is over and above the actual
hospital billing process. Errors can occur due to this additional programming,

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

===
PROVIDER: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Results may not be 100% accurate.

===
PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Burleson St. Joseph Hospital Center uses TX 2400 format to do outpatient data
submission through its vendor Truven Health (http://truvenhealth.com/), formerly
Thomson Reuters.

Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. Burleson St. Joseph Hospital Center
submits more than required outpatient discharges to Truven Health, who then
converts the submitted outpatient records to 837 format and sends all submitted
outpatient records to THCIC data warehouse System 13 Inc
(https://thcic.system13.com). Unwanted outpatient records, defined as those
records containing non reportable revenue codes, are dropped by System 13, Inc.

On Oct 19th 2012, Burleson St. Joseph Hospital was notified by Truven Health
with the following statement:
"Truven Health has been notified that records with a 320 revenue code for your
OP data submission have been excluded from the extracts Truven Health sends to
System 13 beginning with Jan 1, 2012 data. "

Although Truven Health did a resubmission of Q1 2012 outpatient data, it may
contain fewer records than actually occurred. User discretion is advised in
using outpatient data for analysis purposes.

===

PROVIDER: Covenant Childrens Hospital
THCIC ID: 686000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Missing claims: Revenue code 0320 omitted.

==
PROVIDER: Big Bend Regional Medical Center
THCIC ID: 711900
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Reported high as a result of running 2 quarters for this quarter.

==
PROVIDER: CHRISTUS St Michael Rehab Hospital
THCIC ID: 713001
  QUARTER: 1
     YEAR: 2012

Certified With Comments

To the best of my knowledge.

==
PROVIDER: Kindred Hospital North Houston
THCIC ID: 713400
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Some outpatients with revenue code 320 are missing.

==
PROVIDER: CHRISTUS St Catherine Hospital
THCIC ID: 715901
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Still having issues with NPI numbers. Numbers are showing up as incorrect but
are indeed correct.

==
PROVIDER: Kindred Hospital Clear Lake
THCIC ID: 720402
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Some outpatients with revenue code 320 and required procedure codes are missing.

==
PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99
diagnoses and 99 procedures for each patient record. The state is requiring us
to submit ICD-9-CM / CPT data on each outpatient receiving surgical or

radiological services, but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned.

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

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

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

==
PROVIDER: Methodist Willowbrook Hospital
THCIC ID: 724700
 QUARTER: 1
    YEAR: 2012

Certified With Comments

255 records errored out incorrectly and failed to be submitted.

==
PROVIDER: Mother Frances Hospital-Jacksonville
THCIC ID: 725400
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Due to vendor error, approximately 0.4% of records are missing.

```
================================================================================
```
PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Grimes St. Joseph Hospital uses TX 2400 format to do outpatient data submission
through its vendor Truven Health (http://truvenhealth.com/), formerly Thomson
Reuters.

Currently THCIC only requires hospitals to submit outpatient records who
received one or more of the surgical procedures and/or radiological services
covered by some specific revenue codes. Grimes St. Joseph Hospital submits more
than required outpatient discharges to Truven Health, who then converts the
submitted outpatient records to 837 format and sends all submitted outpatient
records to THCIC data warehouse System 13 Inc (https://thcic.system13.com).
Unwanted outpatient records, defined as those records containing non reportable
revenue codes, are dropped by System 13, Inc.

On Oct 19th 2012, Grimes St. Joseph Hospital was notified by Truven Health with
the following statement:
"Truven Health has been notified that records with a 320 revenue code for your
OP data submission have been excluded from the extracts Truven Health sends to
System 13 beginning with Jan 1, 2012 data. "

Although Truven Health did a resubmission of Q1 2012 outpatient data, it may
contain fewer records than actually occurred. User discretion is advised in
using outpatient data for analysis purposes.


```
================================================================================
```
PROVIDER: Green Oaks Hospital
THCIC ID: 766000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.


```
================================================================================
```
PROVIDER: Baylor Medical Center-Frisco
THCIC ID: 787400
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Lower percentage due to ongoing system conversion to the 5010 format


```
================================================================================
```
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge.

==
PROVIDER: Kindred Hospital Tomball
THCIC ID: 792601
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Some outpatients with revenue code 320 and required procedure codes are missing.

==
PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
  QUARTER: 1
     YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

==
PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
  QUARTER: 1
     YEAR: 2012

Certified With Comments

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

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

==
PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
  QUARTER: 1
     YEAR: 2012

Certified With Comments

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

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

==
PROVIDER: Lubbock Heart Hospital
THCIC ID: 801500
 QUARTER: 1
    YEAR: 2012

Elected Not to Certify

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

==
PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

==
PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

==
PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

==
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

===
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

===
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is
only three characters long. Thus any patients discharged with a length of stay
greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is
not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be
creating guidelines for use by hospitals. These guidelines will provide better
clarity for the accurate collection of this data. Hospitals do not routinely
collect race and ethnicity as part of the admission process, that this has been
added to meet the THCIC requirement. Our admissions staff indicates that many
patients are very sensitive about providing race and ethnicity information.
Therefore, depending on the circumstances of the patient's admission, race and
ethnicity data may be subjectively collected. Therefore, the race and ethnicity
data may not provide an accurate representation of the patient population for a
facility.

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

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

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

Claim Filing Indicator Code, Patient Ethnicity, and Diagnosis Code Summary
In the first quarter of 2012, the format for submitting the data to THCIC was
changed to the new 5010 format. With this transition, there were issues with
the data relating to the fields for: Medicare Part A and Medicare Part B codes,
Hispanic Ethnicity, Average Code Count per Encounter, and Principle Code Only.
We suspect that this might be a data mapping issue. However, these issues could
not be corrected before the data was submitted. The issues are being
researched.

===
PROVIDER: Good Shepherd Medical Center-Linden
THCIC ID: 822100
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

===
PROVIDER: Beaumont Bone & Joint Institute
THCIC ID: 826500
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Claims include late 4th quarter claims loaded by System13

===
PROVIDER: Memorial Hermann Rehab Hospital Katy
THCIC ID: 838400
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a revenue code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to revenue code 0320, another

one of the THCIC required Revenue Codes.

==
PROVIDER: University General Hospital
THCIC ID: 840200
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Certified

==
PROVIDER: Texoma Medical Center
THCIC ID: 847000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Data Source. The source of this data, the electronic bill, is administrative in
nature, and was collected for billing purposes. It is not clinical data and
should be cautiously used to evaluate health care quality.
*The billing data file limits the diagnosis codes to 25 (principal plus 24
secondary diagnosis codes); the admission diagnosis and up to nine E-code
fields.
*The procedure codes are limited to 25 (principal plus 24 secondary).
*The fewer the codes the less information is available to evaluate the patients
outcomes and service utilization
*The Hospital can only list 2 physicians that were involved with any one
patient. Other physicians who were involved in those cases will not be
identified.

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

Revenue Codes and Charges. Charges associated with the 1450 data do not
represent actual payments or costs for services.

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

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

==
PROVIDER: Memorial Hermann Northeast
THCIC ID: 847100
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Prior to 10/22/2012, the THCIC Outpatient Technical Specifications Manual
excluded Revenue Code 0320 as a requirement. Thus, the only patients submitted
by Memorial Hermann with a Revenue Code of 0320 prior to the third quarter 2012
submission are patients who incurred, in addition to Revenue Code 0320, another
one of the THCIC required Revenue Codes.

===
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

===
PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

===
PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

===
PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700

```
QUARTER: 1
   YEAR: 2012
```

Certified With Comments

The data reports for Quarter 1, 2012 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

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

```
================================================================================
PROVIDER: Coastal Bend Ambulatory Surgical Center
THCIC ID: 147001
 QUARTER: 1
    YEAR: 2012
```

Certified With Comments

Original certification done on 8-7-12. File was reset by System 13 so certfication is completed again.

```
================================================================================
PROVIDER: DeHaven Surgical Center
THCIC ID: 228002
 QUARTER: 1
    YEAR: 2012
```

Certified With Comments

certified on 072512

```
================================================================================
PROVIDER: South Plains Endoscopy Center
THCIC ID: 278000
 QUARTER: 1
    YEAR: 2012
```

Certified With Comments

The first quarter event list indicates 600 events. This number is not accurate. After some research it was discovered we had multiple errors that were overlooked. Therefore, the second quarter number of events is higher due to the re-submission of the corrected errors of the first quarter.

```
================================================================================
PROVIDER: Platinum Surgery Center
```

THCIC ID: 380000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Lot of patient do not want to give out SS#

==
PROVIDER: Victoria Surgery Center
THCIC ID: 396003
  QUARTER: 1
     YEAR: 2012

Certified With Comments

One diagnosis was missing on one claim. The diagnosis was entered correctly in
our PM system. Not sure why it did not transfer. Also, we never had a chance
to correct any claims for this submission. I submitted the file and a few days
later, I received an email stating that the data set was ready for
certification. No claims were ever availble in the Claim Correct tab.

==
PROVIDER: ACPS Surgicentre
THCIC ID: 709100
  QUARTER: 1
     YEAR: 2012

Certified With Comments

On verifying the reports for the first quarter 2012, (1q2012) I found that two
surgery patients were missing. These patients have been added to the second
quarter (2q2012).

==
PROVIDER: Nacogdoches Surgery Center
THCIC ID: 723800
  QUARTER: 1
     YEAR: 2012

Certified With Comments

As is.
Certification was done on 06/28/12 but still showing needing to certify. Called
and spoke Kathryn and she recommended I just re-cerify as there was a system
glitch that some batches were accidently set to certify again.

==
PROVIDER: SurgEyeCare General Partnership
THCIC ID: 786100
  QUARTER: 1
     YEAR: 2012

Certified With Comments

This batch was done by manual submission as our billing company did not submitt
elecronically as was in the past two quarters.
CK

===
PROVIDER: Clear Fork Surgery Center
THCIC ID: 788900
  QUARTER: 1
     YEAR: 2012

Certified With Comments

There were several accounts with warning flags on them but no warning messages

===
PROVIDER: Medical Village Surgery Center
THCIC ID: 804300
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Upon review, there were two instances where the patients date of service was
inadvertantly entered in lieu of their date of birth, one instance where the
patients control number and the patients medical record number were switched and
one instance where the wrong diagnosis code was entered.

===
PROVIDER: Physicians Surgery Center Longview
THCIC ID: 806400
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Certification of 1st Quarter 2012 and confident that our data is correct from
our computer conversion that occured in 4th Quarter 2011.

===
PROVIDER: Special Surgery of Houston
THCIC ID: 809500
  QUARTER: 1
     YEAR: 2012

Certified With Comments

I have replaced the former surgery center administrator/ceo Michelle Kerr. I
was not employed at Special Surgery of Houston # 809500 during this time period
but will certify to adhere to the compliance requirements.

===
PROVIDER: Headache & Pain Ambulatory Surgery Center
THCIC ID: 809900
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Frequency of Errors Report (Outpatient- Professional)
This report indicates that there was an error on a patient control number on one
claim.

The control number is linked to the invoice number and it is unclear as to why it presented an error on this one claim.

===
PROVIDER: Texas Ambulatory Surgical Center
THCIC ID: 811800
 QUARTER: 1
    YEAR: 2012

Certified With Comments

I apologize for the double entry on (name removed). This was an error. Thank you for letting me know. I will watch for this more closely in the future.
Linda Shafer

===
PROVIDER: Spine Team Texas ASC
THCIC ID: 816200
 QUARTER: 1
    YEAR: 2012

Certified With Comments

 All files complete. Kathy Brooks

===
PROVIDER: Spinecare
THCIC ID: 816900
 QUARTER: 1
    YEAR: 2012

Elected Not to Certify

DATA GENERATED FROM SCHEDULING/BILLING SOFTWARE. WE CANNOT GUARANTEE 100%
ACCURACY.

===
PROVIDER: Dallas Endoscopy Center
THCIC ID: 826200
 QUARTER: 1
    YEAR: 2012

Certified With Comments

we did a spot check on a few claims and they looked accurate. We were having a problem with the 5010 format and current to date it has been resolved.

===
PROVIDER: Texas Health Surgery Center Denton
THCIC ID: 829500
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

==
PROVIDER: Doctors Surgery Center at Huguley
THCIC ID: 831600
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Certified by Rebecca Hernandez

==
PROVIDER: Brazoria County Surgery Center
THCIC ID: 835900
 QUARTER: 1
    YEAR: 2012

Certified With Comments

blake verified

==
PROVIDER: Central Park Surgery Center
THCIC ID: 838000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

I still have not been able to correct the codes (5) that are not a revenue code
that has a charge because we are freestanding. Still working on that with THCIC
and Vision.

==
PROVIDER: Texas Health Outpatient Surgery Center Stephenville
THCIC ID: 838800
 QUARTER: 1
    YEAR: 2012

Certified With Comments

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

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

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

Upon review of the Q1 data, it was discovered that 47 cases that were performed

at the surgery center were submitted with the hospitals data submission. The
cause of the discrepancy is being addressed and corrected.

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is
only three characters long. Thus any patients discharged with a length of stay
greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is
not anticipated that this limitation will affect this data.
Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be
creating guidelines for use by hospitals. These guidelines will provide better
clarity for the accurate collection of this data. Hospitals do not routinely
collect race and ethnicity as part of the admission process, that this has been
added to meet the THCIC requirement. Our admissions staff indicates that many
patients are very sensitive about providing race and ethnicity information.
Therefore, depending on the circumstances of the patient's admission, race and
ethnicity data may be subjectively collected. Therefore, the race and ethnicity
data may not provide an accurate representation of the patient population for a
facility.

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

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

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

==
PROVIDER: Simmons Ambulatory Surgery Center
THCIC ID: 843300
  QUARTER: 1
     YEAR: 2012

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 8,804 staff. Approximately 1,740 patients received
outpatient care in the clinics (both on campus and in the neighborhood-based
health centers) this quarter.

Specific Data Concerns

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

==
PROVIDER: Spine Team Texas Rockwall ASC
THCIC ID: 902000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

All claims completed. KB

==
PROVIDER: CHRISTUS Santa Rosa Physicians Ambulatory Surgery Center
THCIC ID: 917000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

99.3%

```
================================================================================
```
PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

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

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


```
================================================================================
```
PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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


```
================================================================================
```
PROVIDER: Mother Frances Hospital Winnsboro
THCIC ID: 446001
  QUARTER: 1
     YEAR: 2012

Elected Not to Certify

Charge totals are believed to be up to 30% inaccurate as compared to internal
records.


```
================================================================================
```
PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
  QUARTER: 1
     YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

===
PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
 QUARTER: 1
    YEAR: 2012

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.
Administrative data may not accurately represent the clinical details of an
encounter.
The state requires us to submit outpatient claims for patients that receive
outpatient surgical or radiological services, by quarter year, gathered from a
form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data places
programming burdens on the hospital since it is over and above the actual
hospital billing process. Errors can occur due to this additional programming,
but the public should not conclude that billing data sent to our payers is
inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is
not included in the data submission. This represents a rare event that is less
than 1% of the encounter volume.
Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the hospital using a universal standard called the International
Classification of Disease (ICD-9-CM) and Current Procedural
Terminology Codes (CPT Codes). This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes;
however, this is often driven by physician's subjective criteria for defining a
diagnosis. For example, while one physician may diagnose a patient with anemia
when the patient's blood hemoglobin level falls below 9.5, another physician may
not diagnose the patient with anemia until their blood hemoglobin level is below
9.0. In both situations, a diagnosis of anemia is correctly assigned, but the
criteria used by the physician to determine that diagnosis was different. An
apples to apples comparison cannot be made, which makes it difficult to obtain
an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission, or
developed an
infection during their hospitalization. This makes it difficult to obtain
accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be
incomplete due to a limitation on the number of diagnoses and procedures the
state allows us to include for each patient. In other words, the state's data
file may not fully represent all diagnoses treated by the hospital or all
procedures performed, which can alter the true picture of a patient's
hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are
used by hospitals for billing purposes. The hospital can code up to 99 diagnoses
and 99 procedures for each patient record. The state is requiring us to submit
ICD-9-CM / CPT data on each outpatient receiving surgical or radiological
services, but has limited the number of diagnoses and procedures to the first 25
diagnoses codes and the first 25 procedure codes. As a result, the data sent by
us does meet state requirements but cannot reflect all the codes an individual
patient's record may have been assigned.

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

===
PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
 QUARTER: 1
    YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

==
PROVIDER: JPS Surgical Center-Arlington
THCIC ID: 153300
 QUARTER: 1
    YEAR: 2012

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.